# SILVER BLUFF VILLAGE

## PRE-ADMISSION APPLICATION

APPLICANT'S NAME ________________________________________________

PERMANENT ADDRESS ______________________________________________

DATE OF BIRTH _______________ AGE _____ SEX_____ MARITIAL STATUS ___

COUNTY/STATE OF RESIDENCE ___________________ EDUCATION __________

COUNTY/STATE OF ORIGIN ____________________ VETERAN _______________

OCCUPATION (IF RETIRED- PREVIOUS OCCUPATION) _____________________

SPOUSE'S NAME (IF APPLICABLE) _____________________________________

PARENT'S NAME (IF APPLICABLE) _____________________________________

### RESPONSIBLE PARTY

RESPONSIBLE PARTY ________________________ RELATIONSHIP ___________

MAILING ADDRESS _________________________________________________

PHONE (H) _______________ (W) _______________ (CELL) ___________________

EMAIL _______________________

### APPLICANT'S CONTACTS

PLEASE LIST IN ORDER OF CONTACT PREFERENCE

1. NAME ______________________________ EMAIL ______________________
   MAILING ADDRESS _______________________________________________
   PHONE (H) ________________ (W) _______________ (CELL) _____________
2. NAME ______________________________ EMAIL ______________________
   MAILING ADDRESS _______________________________________________
   PHONE (H) ________________ (W) _______________ (CELL) _____________
3. NAME ______________________________ EMAIL ______________________
   MAILING ADDRESS _______________________________________________
   PHONE (H) _______________ (W) ________________ (CELL) _____________

PLEASE LIST OTHER PERSONS TO WHOM THE STAFF OF SILVER BLUFF VILLAGE MAY RELEASE MEDICAL INFORMATION _______________________

_________________________________________________________________

### MEDICAL PROVIDERS

ATTENDING PHYSICIAN ______________________________

DENTIST ____________________ OPTOMETRIST ____________________

OTHERS ______________________________________________________________

### FUNERAL/CREMATION SERVICES

FUNERAL/CREMATIONS SERVICES PREFERENCE _________________________

RELIGIOUS PREFERENCE (IF ANY) ________________

### FACILITY REQUESTS

FACILITY REQUESTED ________________________________

ROOM PREFERENCE: PRIVATE _____ SEMI-PRIVATE _____

## SOCIAL HISTORY

PRESENT LIVING STATUS ________________________________________________
PRIMARY REASON FOR APPLYING FOR THIS PLACEMENT _________________
___________________________________________________________________________
APPLICANT'S RESPONSE TO THIS APPLICATION __________________________
___________________________________________________________________________
FAMILY'S RESPONSE TO THIS APPLICATION _____________________________
__________________________________________________________________________
PERSON WHO MADE DECISION TO APPLY FOR PLACEMENT _______________

## LEGAL STATUS

PLEASE INDICATE WHICH (IF ANY) OF THE FOLLOWING LEGAL DOCUMENTS EXIST FOR THE APPLICANT:

- GUARDIANSHIP _____
  PERSON OR AGENCY DESIGNATED ________________________________
- POWER OF ATTORNEY FOR FINANCIAL MATTERS ______
  PERSON DESIGNATED _____________________________________________
  IS THIS DOCUMENT ON FILE? _____ LOCATION _____________________
- LIVING WILL OR "DESIRE FOR A NATURAL DEATH" _____
- HEALTH CARE POWER OF ATTORNEY _____
  PERSON DESIGNATED AS PRIMARY _______________________________

## APPLICANT PLACEMENT HISTORY

HAS APPLICANT EVER BEEN IN ANOTHER FACILITY? _____
IF "YES", WHERE? ____________________________ WHEN? _____________
WHY DID APPLICANT LEAVE THAT FACILITY? _____________________
__________________________________________________________________
IS APPLICANT CURRENTLY IN A HOSPITAL OR ANOTHER FACILITY? ______
IF "YES", WHY IS APPLICANT SEEKING THIS PLACEMENT? __________
_________________________________________________________________
HAS APPLICANT EVER RECEIVED SERVICES FROM HOME HEALTH, CAP, OR OTHER LOCAL HEALTH SERVICES? _____ IF "YES" WHEN AND WHY? ______
__________________________________________________________________________

## APPLICANT BEHAVIORS

PLEASE CHECK ALL THAT APPLY:
COOPERATIVE WITH CAREGIVERS _____ FRIENDLY _____
HOSTILE _____ WITHDRAWN _____ PRONE TO WANDER _____
ATTEMPT TO LEAVE _____ PHYSICALLY/VERBALLY ABUSIVE _____
ABLE TO SLEEP THROUGH THE NIGHT _____ OTHER (PLEASE SPECIFY) _____________________________________________________
DOES APPLICANT USE TOBACCO PRODUCTS? _____IF SO, WHAT? ________
HAS APPLICANT RECEIVED TREATMENT FOR EMOTIONAL/MENTAL ILLNESS? _____ IF SO, WHERE? ___________________________________________

**PHYSICAL CONDITION**

(TO BE COMPLETED BY THE PERSON SUBMITTING THE PRE-ADMISSION APPLICATION)

APPLICANT'S PRIMARY HEALTH PROBLEMS ______________________________
______________________________________________________________________

DOES APPLICANT HAVE DRESSINGS/BANDAGES? _____
IF SO, WHERE? ______________________________________________________

DOES APPLICANT HAVE DECUBITUS (BED SORES)? _____
IF SO, WHERE? ______________________________________________________

DESCRIBE ANY ABNORMAL SKIN PROBLEMS APPLICANT MAY HAVE ______
____________________________________________________________________

DOES APPLICANT HAVE A CATHETER? _____ COLOSTOMY? _____

CHECK APPROPRIATE TUBES (IF APPLICABLE) FOLEY _____ LEVINE _____
STOMACH _____ CHEST _____ IV/FLUIDS _____ OXYGEN _____
SUCTION _____ BREATHING _____ OTHER (PLEASE SPECIFY)_________

**PHYSICAL CAPABILITIES**

| | INDEPENDENT | SOME ASSISTANCE | TOTAL DEPENDENCE |
|---|---|---|---|
| FEED SELF | ______________ | __________________ | ____________________ |
| DRESSING | ______________ | __________________ | ____________________ |
| TOLIETING | ______________ | __________________ | ____________________ |
| TRANSFER | ______________ | __________________ | ____________________ |
| REPOSITION (IN BED) | ______________ | __________________ | ____________________ |
| ELIMINATION: | | | |
| BOWELS | ______________ | __________________ | ____________________ |
| BLADDER | ______________ | __________________ | ____________________ |

IF INCONTINENT, WHAT SIZE OF PADS/BRIEFS ARE USED? ___________

**PHYSICAL/MENTAL ASSESSMENT**

MENTAL STATUS: (CHECK ALL THAT APPLY) ALERT _____ SEMI-ALERT ____
CONFUSED _____ (IF CONFUSED, WHAT TIME OF THE DAY DOES THE CONFUSION SEEM TO BE WORSEN? AM __ NOON __ EARLY EVENING __ AT NIGHT ___

DENTURES: NONE __ UPPERS __ LOWERS __ BOTH __ PARTIALS __ USED? __

VISION: NORMAL __ SIGHTLY IMPAIRED __ VERY IMPAIRED __ GLASSES? __
OTHER VISION PROBLEMS ________________________________________

HEARING: NORMAL __ SLIGHTLY IMPAIRED __ VERY IMPAIRED __
HEARING AIDS __ OTHER HEARING PROBLEMS ____________________

SPEECH: CLEAR __ SLIGHTLY UNCLEAR __ VERY UNCLEAR __ OTHER SPEECH PROBLEMS__________________________________

AMBULATION: NORMAL (NO AIDS) __ NORMAL WITH AIDS (WALKER/CANE) __ ABLE TO WALK BUT USES WHEEL CHAIR __ NON-AMBULATORY (WHEELCHAIR) __ BEDFAST __

DIET: REGULAR __ CHOPPED/GROUND/PUREE/MEAT __ TOTAL PUREE __

THERAPY NEEDS: PHYSICAL __ OCCUPATIONAL __ SPEECH __

**FINANCIAL INFORMATION**

APPLICANT'S FULL (LEGAL) NAME ______________________________________
SOCIAL SECURITY NUMBER _______________
MEDICARE: YES _____ NO _____ IF YES- CLAIM NUMBER _______________
PART A- EFFECTIVE DATE _____________________
PART B- EFFECTIVE DATE _____________________
MEDICARE D: YES _____ NO _____
IF YES- PLAN AND CLAIM NUMBER ______________________________
_________________________________________________________________
MEDICAID: YES ______ NO _____ NUMBER ______________________________
EFFECTIVE DATE _________________
IF NO, WILL APPLICANT APPLY? _____
APPLICATION PENDING? ______ AS OF WHAT DATE? __________
INSURANCE: NAME OF INSURER- ________________________________________
POLICY OR GROUP NUMBER ________________________________
ADDITIONAL INSURANCE ___________________________________

| MONTHLY INCOME: | AMOUNT |
|---|---|
| SOCIAL SECURITY | _______________ |
| RETIRMENT/PENSION | _______________ |
| VETERAN'S BENEFITS | _______________ |
| RAILROAD BENEFITS | _______________ |
| INVESTIMENTS | _______________ |
| INTEREST INCOME | _______________ |
| RENTAL | _______________ |
| OTHER INCOME | _______________ |
| OTHER ASSETS: | |
| BANK ACCOUNTS | _______________ |
| SAVINGS ACCOUNTS | _______________ |
| CERT. OF DEPOSIT | _______________ |
| OTHER | _______________ |

_______________________________________________ _________________
SIGNATURE OF APPLICANT OR REPRESENTATIVE DATE

***The information submitted on this application is for the purpose of assessing the applicant for possible admission to Silver Bluff Village, Inc.. This information will be used only for this purpose and will not be made available to any other party, without the expressed written consent of the applicant and/or the legal representative of the applicant.***
***Silver Bluff Village, Inc.***