

**Dogwood Village of Orange County**

**Health and Rehab**

**Application for Admission**



<b><u>Applicant's Name:</u></b>	<b>Date Received:</b>
<b>Address:</b>	<b>Phone #</b>
<b>Person to contact when Appropriate Bed is ready:</b>	<b>Phone #</b>
<b><u>Personal Information:</u></b>	<b>Social Security #</b>
<b>Place of Birth:</b>	<b>Date of Birth:</b>
<b>Gender:</b>	<b>Marital Status:</b>
<b>Medical Power of Attorney:</b>	<b>Guardianship:</b>

**Current Treatment Plan:**

List medications, Care Plans, Therapies-Please furnish copies if available:

Names and addresses of all Hospitals, Nursing Homes & Assisted Living Facilities from which patient was discharged in the past 90 days, to include dates of stays:

<b>Date of Last Hospital Stay (within the last 90 days):</b>	<b>Admission:</b>	<b>Discharge:</b>
<b>May we request information from the hospital or Nursing Home?</b>	<b>Yes or No</b>	

**Medical Information:**

<b>Physician Name:</b>	<b>Phone #</b>
<b>Address:</b>	
<b>May we request a copy of your medical records? Yes Or No</b>	
<b>Date of last Physical:</b>	<b>Is copy available?</b>
<b>Diagnosis:</b>	
<b>Primary:</b> _____	
<b>Secondary:</b> _____	
_____	

If Dementia is listed, is wandering a problem or risk? YES Or NO

Are there behavior problems we need to be aware of? YES Or No

Please describe:

**Dental Information:**

Name:	Phone #
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Address:

<b><u>Religious Information:</u></b>	Name of Church:
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Clergy Name:	Phone #
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Address:

**Insurance Information:**

Medicare #	Medicare D #
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Supplemental Insurance, Name, Address & Phone #:	Insurance Policy & Group #
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Hospice (please circle one):      yes or no      If yes, which agency:

Representative Payee (name, address & phone number):

Is there Long Term Care Ins.? Yes or No If yes; name, address, phone & policy #

**Responsible Party Information:**

Name:	E-mail:
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Address:

Phone #'s	Home	Work	Cell
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**Person(s) to notify in case of Emergency**

1)Name & Address:	Home Phone:
	Work Phone:
	Cell Phone:

2)Name & Address:

Home Phone:

Work Phone:

Cell Phone:

**Financial Information**

Are there private funds enough to cover 6 months? Yes Or No

Financial  
POA?

Are you approved for Medicaid Assistance through DSS? Yes Or No

Agency:

May we share information with this agency? Yes Or No

Medicaid  
#

Date of Application

Date of  
U.A.I

Name of Case Worker

Phone #

**Laundry Services (circle one):**    *Self*                      *Family*  
*Facility*

**Mortuary Preference (please include address and phone #):**

*It is the policy of the facility that no one shall be discriminated against on the grounds of race, color, natural origin, or age. The facility shall at all times be in full compliance with Title VI of the Civil Rights Act of 1964(P.L. 88-353, Section 504 of Rehab act of 1973) and regulations issued by the Department of Health & Human Services (45 C.F.R. Part 80) pursuant to these titles.*

**Signature of Applicant:**

**Date:**