EMERSON
HEALTH & REHABILITATION CENTER

MEDICAL INFORMATION

***To Be Completed By Applicant's Physician*:**

Applicant's Name: _____ **Date:** _____

Address: _____

Date of Birth: _____

Sex: _____

Primary Diagnosis: _____

History & Physical:

_____

_____

_____

_____

_____

Vital Signs: Temp: _____ Pulse_____ Resp _____ BP _____

Height: _____ **Weight**: _____ **Current Diet:** _____

Date of Last Exam: _____

Mental Status: □ Alert □ Oriented □ Confused

Behavioral Issues (Specify):_____

_____

Bowel: □ Continent □ Incontinent **Bladder**: □ Continent □ Incontinent □ Other

Current Medications: _____

_____

_____

_____

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Please check off those that best pertains to this patient:

□ Ambulatory □ Cane □ Walker □ Wheelchair □ Bedbound

□ Hearing Aids □ Glasses □ Blind □ Deaf

PHYSICIAN INFORMATION:

Name: _____ Telephone: _____

Address: _____

HOSPITALIZATIONS WITHIN THE LAST 12 MONTHS:

Hospital: _____ Date:_____ Diagnosis: _____

Hospital: _____ Date:_____ Diagnosis: _____

History of Mental Illness: □ Yes □ No

Diagnosis: _____ Treatment:_____

Has this applicant ever been a patient in a skilled nursing facility? □ Yes □ No

If so, When ?_____ Where? _____

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The following information is to be completed by the Responsible Party:

Applicant's Name: _____ Date:_____

Address: _____

Primary Care Physician: _____

Date of Birth:_____ Place of Birth:_____

Marital Status: _____ Sex: _____

US Citizen? □ Yes □ No If not, Alien Registration #:_____

Education: _____ Occupation:_____

Social Security No: _____ Medicare No:_____

Health Insurance Company: _____

Prescription Drug Plan: □ Yes □ No Policy No:_____

Please list Persons of Contact:

1. Name: _____ Relationship: _____

   Address: _____

   Home Phone: _____ Business Phone:_____

2. Name: _____ Relationship: _____

   Address: _____

   Home Phone: _____Business Phone:_____

3. Name: _____ Relationship: _____

   Address: _____

   Home Phone: _____Business Phone:_____

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MONTHLY INCOME:

Social Security: _____ Pension: _____ Other: _____

ASSETS:

Total Savings: _____ Total Checking: _____

Total in Stocks, CD's, Bonds: _____

Property Owned: _____

MEDICAID INFORMATION:

Eligible for Medicaid: □ Yes □ No

Medicaid Pending: □ Yes □ No

Have you applied for Medicaid: □ Yes □ No

Date:_____ County: _____ Case Manager: _____

Name of Power of Attorney Responsible for the Finances: _____

Relationship: _____ Address: _____

Financial Correspondence should be mailed to: _____

_____

How did you hear about Emerson Health Care Center?_____

Why are you seeking admission at this time?_____

_____

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FALSE INFORMATION GIVEN INTENTIONALLY
WILL INVALIDATE THIS APPLICATION

PLEASE INCLUDE 2 YEARS OF TAX RETURNS

_____ _____

Signature of Applicant (if possible) **Date**

_____ _____

Signature of Person Completing Application **Relationship**

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Please bring copies of the following documents prior to or at time of Admission:

- Medicare Card
- Secondary Card
- Prescription Card – some prescriptions may be included in the secondary insurance plan.
- Social Security Card
- Proof of Citizenship (Birth Certificate, Passport, etc.)
- Power of Attorney Document
- Living Will, Advance Directive, or Health Care Proxy Document
- Long Term Care Insurance policy information
- For private paying residents a check representing one month in advance and one month security deposit. In addition, we will need to photocopy any proof of assets for the purpose of any future Medicaid services. A proof of asset may include any of the following: most recent monthly bank statement; mutual fund account statements; annuity statements; stock certificates; CD's; or life insurance cash value statements.

If you have any questions regarding the application process, please feel free to contact Danielle or Season in the Admissions Office.