WINDER HEALTHCARE
& Rehabilitation Center

APPLICATION FOR ADMISSION

Applicant's Name:_____ **Application Date**_____/_____/_____
First M Last Mo Day Year

How did you hear about Winder Healthcare?_____

I. GENERAL INFORMATION

Applicant's Date of Birth: _____ **Age:** _____ **Social Security Number:** _____
Applicant's Current Location: _____

Most Recent Address: _____

Marital Status: _____ **Religion:** _____ **Education:**_____

Occupation:_____ **Military Service:** _____

Current Diagnosis: _____ **Height:** _____ **Weight:** _____

Does applicant currently smoke? Yes / No

Is applicant aware of placement decision? Yes/ No Explanation: _____

Does applicant need a memory-care unit/ lock-down facility? Yes/ No_____

Is applicant wheelchair/ bedbound? Yes/ No Explanation: _____

Does applicant have any current behaviors? Yes/ No Explanation: _____

Has applicant had a previous stay(s) in the past year to the hospital or other nursing facility? Yes / No

Date of Stay	Name of Facility	Reason/Services Received
___/___/___	_____	_____
___/___/___	_____	_____

Has the applicant received any of the following services?

_____**Home** Health Services _____Geriatric Care Management _____Adult Protective Services

_____Hospice _____Attorney: If yes, name:_____

Does the applicant have: Pre-paid burial? Yes / No Pre-selected Funeral Home? Yes / No

If Yes, Name:_____

II. INSURANCE

Medicare Number:_____**Is Medicare Primary? Yes**_____**No** _____

If Medicare is not primary-other insurance:_____ **Policy#**_____

Supplemental Health Insurance:_____ **Policy#** _____

Pharmaceutical Plan:_____ **Policy #** _____

Long Term Care Insurance: Circle One Yes / No Has the policy been activated? Yes / No

If Yes, List Provider: _____**Policy #** _____

Daily Amount: $_____**Total Value: $**_____

III. RESPONSIBLE PARTY INFORMATION

Healthcare Contact: List person holding the Healthcare Power of Attorney or the person who will be contacted for medical needs.

Is the Healthcare contact the same as the billing contact: Yes / No (if no, please complete section below)

Name:_____ **Relationship:** _____

Address: _____

Phone Numbers:

Home: _____ **Work:** _____ **Cell:** _____

E-Mail Address: _____

Financial Contact: (person who will be receiving the monthly bill):

Name:_____ **Relationship:** _____

Address: _____

Phone Numbers:

Home: _____ **Work:** _____ **Cell:** _____

E-Mail Address: _____

Other/Back-Up Emergency Contact:

Name:_____ **Relationship:** _____

Address: _____

Phone Numbers:

Home: _____ **Work:** _____ **Cell:** _____

E-Mail Address: _____

IV. FINANCIAL PROFILE

Monthly Income **Social Security** **$**_____

Monthly Rental Income $_____

Retirement/Pension $_____ Other:_____ $_____

<u>Residence</u> Does applicant own a home? Yes / No

Value (Approximate) $_____ Mortgage (Approximate) $_____

Is the property jointly owned? Yes / No Name of Co-Owner:_____

<u>Assets</u> (Current Balance)

Are the applicant's assets held individually? Yes / No If joint, with whom are they held?_____

Savings Account (s) $_____ Stocks/Bonds $_____

Checking Account (s) $_____ Life Insurance $_____

Certificates of Deposit $_____ Other (Describe) $_____

***Has the applicant sold a home or transferred assets to anyone in the last 5 years? Yes_____No_____**

If Yes, please provide details:_____

<u>Liabilities</u> (Medical Bills, Credit Cards, Charge Accounts, Loans)

Dollar Total $ _____

Specify Liabilities: _____

Once admission is confirmed, please provide the following:

- The front and back of all insurance cards;
- Copies of any Power of Attorney documents;
- Copies of any Guardianship documents;
- Copies of Living Will and or Advance Directives.

I hereby attest that the above Financial Information is accurate and <u>assets are available for the Resident</u> to pay for services received at Winder Healthcare and Rehabilitation Center. It is understood that Winder Healthcare relies on the accuracy and completeness of the information furnished in order to make an Admission Decision.

I understand that when Medicare coverage or other primary insurance benefits end, the resident will need to pay privately or be eligible for Georgia Nursing Home Medicaid. I certify that all information provided is accurate and complete as of this date, and I understand that any information provided will be used only for the application process and potential admission. I also direct and authorize Winder Healthcare and Rehabilitation Center to give and receive information from any medical or social work practitioner, social agency, clinic, hospital or nursing home where the resident has been or will potentially be treated.

_____ _____

Family / Responsible Party Signature **Date**

This application must be filled out completely in order to process your admission into our facility. If there is not a bed available at the time you submit this application or if you are not ready to admit your loved one, please, feel free to check back with us on availability. All information will be kept confidential.

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www.winderhealthcare.com