APPLICATION FOR ADMISSION TO GRANT REHABILITATION AND CARE CENTER

THE INFORMATION ASKED FOR ON THIS FORM IS NEEDED TO EVALUATE THE APPLICANT'S REQUEST FOR ADMISSION. PLEASE COMPLETE THIS FORM TO THE BEST OF YOUR ABILITY AND RETURN TO:

SOCIAL SERVICES
GRANT REHABILITATION AND CARE CENTER
127 EARLY AVENUE
PETERSBURG, WV 26847
(304)-257-4233 EXT. 5239
(304)-530-5940 (FAX)

ALL INFORMATION WILL BE CONSIDERED BY THE ADMISSIONS COMMITTEE AND WILL BE HELD IN STRICT CONFIDENCE. THE ACCEPTANCE OF THIS FORM DOES NOT BIND EITHER PARTY TO ADMISSION.

DATE_____

1. NAME_____ SEX_____
   LAST FIRST MIDDLE

   ADDRESS_____
   STREET TOWN STATE ZIP CODE

   AGE _____ SOCIAL SECURITY NUMBER_____ TELEPHONE_____

   DATE OF BIRTH_____ PLACE OF BIRTH_____
   TOWN COUNTY STATE

   EDUCATION LEVEL _____

   PRESENT MARITAL STATUS: SINGLE☐ MARRIED☐ WIDOWED☐ DIVORCED☐
   DATE DATE

2. FATHER'S NAME_____ MOTHER'S MAIDEN NAME_____

   FATHER'S BIRTHPLACE_____ MOTHER'S BIRTHPLACE _____

3. NAME OF SPOUSE _____ PLACE OF BIRTH _____

4. HAVE YOU BEEN CONVICTED OF A FELONY? YES☐ NO☐
   Conviction will not necessarily disqualify an applicant from placement.

   If yes, please explain: _____

_____

5. LIST BELOW, BEGINNING WITH THE ELDEST, EACH LIVING CHILD: (IF NONE, LIST NEAREST RELATIVE)

NAME & RELATIONSHIP ADDRESS TELEPHONE

_____
_____
_____
_____
_____

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6. POWER OF ATTORNEY: NAME, ADDRESS, AND TELEPHONE: _____
_____

MEDICAL POWER OF ATTORNEY: NAME, ADDRESS, AND TELEPHONE _____
_____

EXECUTOR OF ESTATE: NAME, ADDRESS, AND TELEPHONE_____
_____

7. CHURCH NAME, ADDRESS, AND TELEPHONE NUMBER _____
_____

PASTOR'S NAME, ADDRESS, AND TELEPHONE NUMBER _____
_____

9. PERSONAL PHYSICIAN'S NAME, ADDRESS, AND TELEPHONE NUMBER _____
_____

10. GENERAL STATE OF HEALTH (LIST MAJOR HEALTH PROBLEMS AND DISABILITIES): _____
_____
_____
_____

A. PLEASE CHECK THE FOLLOWING AS TO YOUR STATE OF HEALTH:

EATING: FEEDS SELF_____ NEEDS SOME HELP_____ MUST BE FED_____

SPECIAL DIET: _____ WHAT TYPE OF DIET? _____

BATH: BATHES SELF _____ NEEDS HELP _____ NEEDS TO BE BATHED _____

BEHAVIOR: ALERT _____ CONFUSED AT TIMES _____ ALWAYS CONFUSED_____

WANDERS_____ TALKS OUT LOUD AT NIGHT_____ COMBATIVE _____

AMBULATION: WALKS ALONE_____ NEEDS ASSISTANCE_____CANNOT WALK_____

USE OF ANY DEVICE, IF YES, GIVE TYPE_____

LOSS OF CONTROL OF BLADDER/BOWEL:

ALL THE TIME _____ NIGHTS ONLY_____ NEVER _____

WEARS DIAPERS_____ CATHETER: YES_____ NO_____

BEDSORES: YES _____ NO_____

DO YOU EVER REQUIRE OXYGEN? YES____ NO____ IF YES, WHEN? _____
_____

VISION: GOOD _____ FAIR_____ POOR_____ BLIND_____
DO YOU WEAR GLASSES? YES_____ NO_____

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ANY ACUTE PROBLEMS WITH EYES? _____

HEARING: GOOD: ☐ HARD OF HEARING: ☐ USES HEARING AID ☐

B. MEDICATIONS PRESENTLY BEING TAKEN ARE: _____

_____

_____

_____

C. ALLERGIES: _____

11. PAST OCCUPATIONS: _____

12. HOBBIES OR INTERESTS: _____

_____

13. INSURANCE

HEALTH? _____ COMPANY_____

HEALTH INSURANCE CLAIM NUMBER: _____

ADDRESS_____

OTHER_____

MEDICAID NUMBER: _____ MEDICARE NUMBER:_____

PART A: ☐ YES ☐ NO EFFECTIVE DATE:_____

PART B: ☐ YES ☐ NO EFFECTIVE DATE:_____

14. ARRANGEMENTS CONCERNING YOUR BURIAL? FUNERAL DIRECTOR TO BE CALLED, ADDRESS, & TELEPHONE NUMBER:_____

_____

HAVE YOU DONATED ANY ORGANS OR ENTIRE BODY AT DEATH TO MEDICAL RESEARCH? _____

_____

DO YOU DESIRE ANY AUTOPSY AT DEATH? YES☐ NO☐

15. IS THERE ANY SPECIAL DATE BY WHICH YOU DESIRE TO ENTER THE FACILITY? _____

WHY? _____

_____

I CERTIFY THAT I HAVE READ THE ADMISSION POLICY OF GRANT REHABILITATION AND CARE CENTER OR HAVE HAD IT EXPLAINED TO ME, AND APPLY ADMISSION WITH THE UNDERSTANDING THAT THESE CONDITIONS WILL APPLY TO ME AS A RESIDENT IN THE FACILITY.

_____

APPLICANT'S SIGNATURE OR POWER-OF-ATTORNEY OR NEAREST RELATIVE

DATE APPLICATION WAS RECEIVED: _____

APPLICATION RECEIVED BY: _____

STAFF PERSON