Office Used Only
Date Received----------

Little Sisters of the Poor Holy Family Home for the Elderly

APPLICATION FOR ADMISSION ------Skilled ------Apt

Name ---------- Date ----------

Birth Date ---------- Age --------- Nationality---------- Citizenship ----------

Sex ----- Marital Status ------- Social Security ---------- Veteran Y/N Branch ----------

Address ---------- City---------- Zip Code----------

Contact Number ---------- Email ----------

Religion ---------- Church or Parish ----------

Pastor's Name ---------- Address ----------

Name of Spouse ---------- Living Y/N If yes Date of Death ----------

Address ----------

Father's Name ---------- Mother's Maiden Name ----------

Financials

Former Occupation ---------- Last Employer ----------

Employment Date---------- Pension ---------- Life Ins. Y/N Face Value ----------

Sources of Present Income---------- Amount ----------

Other income ---------- ---------- ----------

Savings Amount ---------- Checking Amount---------- Stocks and Bonds ----------

Real Estate Y/N Location ---------- Value ---------- Sold/transfer date------

Other Assets ---------- ---------- ----------

Locked Box Y/N Location ---------- Other Income----------

Debts Y/N Explain ----------

Amount ----------

Insurances

Medicare Y/N Number ---------- Part A ---- Part B ---- Hospital Y/N Number ----------

Other Ins. Y/N Number ---------- Yearly Premium ----------

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Next of Kin

Name	Relationship	Phone & Email Address
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----------	----------	----------

Medical

Medical Conditions/Diagnosis

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Mental Health or Psychiatric Care **Y/N** Present Need of Mental Health or Psychiatric Care **Y/N**
Drug and Alcohol Dependency Y**/N** Depression Y**/N** Anxiety **Y/N** Dementia/Confusion **Y/N**

Vaccination History/Date
Tetanus booster/TdaP ------ Pneumovax -------- Flu ------ Prevnar ------- Shingles -------- COVID-19 --------

Surgeries/Hospitalizations

Dates	Type
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Nursing Home Stays ----------

Current Medications

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Primary Physician's Name ---------- Phone ----------
Specialists Name and Last Visit

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Medical Decisions

Power of Attorney ----------

Advance Directives/Living Well ----------

Burial Arrangements ----------

Activity of Daily Living

EATING ---- Independent ---- Needs Assistance

DRESSING AND GROOMING ----Independent ---- Needs Assistance

PERSONAL HYGIENE ---- Independent ---- Needs Assistance

MEIDCATIONS ---- Independent ---- Needs Assistance

TOILETING NEEDS ----Independent ---- Needs Assistance

TRASFER ---- Independent ---- Needs Assistance/devices

MOBILITY ------Independent ---- Needs Assistance Cane ---- Walker ---- Wheelchair

LAUNDRY -----Independent ---- Needs Assistance

HOUSEKEEPING -----Independent ---- Needs Assistance

SHOPPING -----Independent ---- Needs Assistance

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Signature of Candidate & Date Signature of Person Completing this Form & Date

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