

**TOLSTOY FOUNDATION REHABILITATION & NURSING CENTER * APPLICATION FOR
ADMISSION – Page 2**

Responsible Parties in decision making:

<u>Name</u>	<u>Address</u>	<u>Tel. # (Home/Business)</u>	<u>Relationship</u>

Person to be notified in the event of illness: _____

_____ **ANY TIME** day or night _____ Between 8AM & 10 PM _____ At time of death only

Do all children know about this application: _____ Yes _____ No

Physician's Name: _____ Address: _____ Tel.# _____

Dentist's Name: _____ Address: _____ Tel. # _____

Will Physician Care for Patient in Nursing Home: _____ Yes _____ No

Existing Health Care Advance Directives (check all that apply and attach copies)

_____ Health Care Proxy _____ Living Will _____ Do Not Resuscitate

_____ Feeding Restrictions _____ Other

Will you be in need of financial assistance? _____ Yes _____ No

Social Security Pension Amount: \$ _____ Receives at: _____

Name & Address of
Other Income Source and Amount: _____

If there is no Medicaid Number for Chronic Care – copies of 36 months of financial information in requested with application.

Bank Accounts & Names of Signors: _____

Bank _____ Account # _____ Amount _____

Property Owned: _____ Value: \$ _____

Name of Life Insurance Policy and Number, Including Cash Value: \$ _____

Do you have a will? _____ Yes _____ No

Are you a veteran? _____ Yes _____ No Is your spouse a veteran? _____ Yes _____ No

Present or Past Union Member? _____ Yes _____ No Benefits: \$ _____

Burial Pre-Arrangements:

Person responsible for burial arrangements: _____

Funeral Home Preference: _____ Plot Location: _____

Burial Fund: _____ Yes _____ No With: _____

NOTE: If a preference is not indicated above by you, in the event of death, the Tolstoy Foundation Nursing Home will call upon a local funeral home for holding.

1. I understand admission is based on medical need and therefore authorize Tolstoy foundation Nursing Home to request any and all medical information necessary.
2. I understand the Bed Retention Policy, which was attached to the admission application.
3. I understand that the attending physician may be calling in medical consultants when he Deems it necessary, and that I will be informed in advance if any invasive procedures are advised.

Signature: _____

Relationship (if other than Applicant): _____

Date: _____

Federal and state laws prohibit discrimination based on race, sex, handicap, disability, color, creed, blindness, religion, national origin, source of payment, marital status, age, sexual preference and retention and care of Residents.

Revised November, 2007

Name of Applicant: _____

Religion: _____ Name of Clergy: _____

If Eastern Orthodox – Saint’s Day _____

Spouse’s Name: _____ Spouse’s Occupation: _____

Date of Marriage: _____ Place of Marriage: _____

If deceased, give date: _____ Any Previous Marriages? _____

Father’s Name: _____ Mother’s Maiden Name? _____

Father’s Occupation: _____ Mother’s Occupation: _____

How many brothers/sisters older than you: _____ Younger than you: _____

Children’s Names: _____

How Many Grandchildren: _____

Languages Spoken: _____ Education: _____

Occupation/Skill: _____ Work History: _____

Last Place of Employment: _____

Retirement Date: _____ Occupation after Retirement: _____

Community Involvement: _____

Registered to Vote? Yes No

Wish to Vote by Absentee Ballot? Yes No

FAVORITE ACTIVITIES. Please check as many as apply.

	Past	Present		Past	Present
Church	_____	_____	Gardening	_____	_____
Cooking	_____	_____	Games:		
Crafts:			Bingo	_____	_____
Crocheting	_____	_____	Board/Cards	_____	_____
Woodwork	_____	_____	Bridge	_____	_____
Painting	_____	_____	Pets	_____	_____
Needlework	_____	_____	Reading	_____	_____
Cultural Events:			Shopping	_____	_____
Ballet	_____	_____	Thinking	_____	_____
Musical	_____	_____	TV/Movie	_____	_____
Singing	_____	_____	Visiting	_____	_____
Theater	_____	_____	Walking	_____	_____
Current Events	_____	_____	Other	_____	_____
Exercise/Sports	_____	_____			