FOX MEADOW RETIREMENT HOME, LLC
Application For Placement

Date: _____

General Information

Name: _____ D.O.B.: _____ Age: _____

Social Security #: _____ Place of Birth: _____

Address and Telephone #: _____

_____

Currently Residing at: _____

Is this applicant aware of the possibility of placement?_____

Marital Status: _____ Religion: _____ Church: _____

Previous Occupation: _____ Military Service: _____

Education: _____

Language(s) spoken: _____

Primary Care Physician: _____ Phone: _____
Is the Primary Care Physician aware of the possibility of placement? _____

Contact Information

Individual responsible for health care decisions (P.O.A., Guardian over person, etc.)

Name: _____
Address: _____
_____
Phone: _____
Relationship to applicant: _____

Individual responsible for finances. Please specify legal representation, if any.

Name: _____
Address: _____
Phone: _____

Additional Contacts

Name: _____
Address: _____
Phone: _____
Relationship: _____

Insurance Information

Medicare #: _____ Effective Date: _____ Part A or B? ___

Other Insurance Information: _____

Financial Information

Monthly Income (please specify amounts):

Social Security: _____

VA Pension: _____

Retirement: _____

All other income: _____

Balance in checkbook, savings account, or other forms of deposit. Please be specific and provide photocopies of information, if available. _____

Please list stocks, bonds, or other securities (market value and annual income received): _____

Does the applicant own his or her own home/property? Please specify approximate value. _____

Does the applicant have a life insurance policy? If yes, please specify approximate cash value. _____

Does the applicant have pre-paid funeral arrangements? _____

Please specify funeral home preference. _____

Are any of the above assets jointly held? If yes, please specify with whom:

_____

_____

_____

Medicaid/Title XIX

Has the applicant applied for Medicaid assistance or does the applicant anticipate the need to apply for Medicaid assistance? Please explain.

_____

_____

_____

Under penalty of perjury, I hereby attest that to the best of my knowledge the above information is true and accurate.

Name of person providing information (please print): _____

_____ _____

Signature of person providing information Date

PERSONAL ASSESSMENT

Applicant name: _____

Please provide as much information as possible for the following areas.

Current Diagnoses and Past Medical History:

_____

_____

_____

Current Medications:

_____

_____

_____

Communication Ability: _____

_____

Ambulation/ Movement (please specify if applicant used any devices):_____

_____

_____

Bathing:_____

_____

Activities of Daily Living (dressing, combing hair, brushing teeth, shaving, etc.): _____

_____

_____

Eating Habits (please include special diet requirements or dietary preferences): _____

_____

_____

Is the applicant able to feed self?_____

Bowel and Bladder Habits (please specify if applicant experiences incontinence): _____

_____

Vision and Hearing _____

Sleeping Habits (please include usual sleeping hours):_____

_____

Behavior (for example: friendly, cooperative, depressed, confused, withdrawn, belligerent, etc): _____

_____

Hobbies: _____

Music Preferences: _____

Please include any additional information about the applicant:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Under penalty of perjury, I hereby attest that to the best of my knowledge the above information is true and accurate.

Name of person providing information (please print): _____

_____ _____

Signature of person providing information Date

_____ _____

Signature of Facility Representative Date