

## BERKELEY SPRINGS REHABILITATION AND NURSING CENTER Pre-Admission Application

Applicant Name		Sex: M      F	Date of Birth: /   /	Age:
Social Security #	Medicare#	Medicaid #	Other Insurance:	
Address:			Telephone:	
			Height	Weight
Primary Diagnosis : _____				
Secondary Diagnosis: _____				
Does the applicant have a diagnosis of Alzheimer's Disease or Dementia? Y / N ; Stage if known: I II III				

### MEDICATIONS

Attending Physician:	Pharmacy:
1.	2.
3.	4.
5.	6.
7.	8.
9.	10.
<b>PAS2000 Level of Care:</b> Nursing Home Level II required and done Skilled for _____	Previously lived: Alone      with Spouse/Significant Other with Family/Friend Other: _____
Admitting From: Home   Assisted Living   Nursing Home   Other: _____ Hospital - Name: _____ Dates of most recent stay from _____ to _____	
Has resident ever been in an institution for the mentally ill or mentally retarded?    Yes    No    If yes, indicate the name of the facility, dates of stay and location: _____	

### APPLICANT INFORMATION

Person Making Application: Same as Responsible Party? Y / N If no, Name of Applicant: _____ Relationship: _____ Address: _____ Telephone: _____
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### LEGAL REPRESENTATIVE

Name of Legal Representative: _____ Address: _____ _____ Telephone: _____
<b>Relationship:</b> Self    Guardian    Conservator    Power of Attorney    Medical Power of Attorney Guardian Proceedings    Durable Power of Attorney    Health Care Surrogate

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### ADVANCE DIRECTIVES/DECISION-MAKING

**Capacity:** Has Capacity    Lacks Capacity    Date of last Evaluation of Capacity: \_\_\_\_\_  
 Advance Directives:    Full Code    No Code    Conditions: \_\_\_\_\_

If lacking capacity, prospective resident has been informed that Legal Representative is making decisions.  
 No Legal Representative is in place, Health Care Surrogate is Needed.  
 Prospects to Serve as Health Care Surrogate: \_\_\_\_\_

### FINANCIAL INFORMATION

#### Payment Status:

Medicare #Days used \_\_\_\_\_    Medicaid    Private Pay    Commercial Insurance    VA    Managed Care  
 Other: \_\_\_\_\_

**Income Sources:** \_\_\_\_\_    **Monthly Income:** \_\_\_\_\_

**Financial Counseling Needed:**    Yes    No; Understands Coverage:    Yes    No

Comments: \_\_\_\_\_

### BACKGROUND

<b>Birthplace:</b> _____		<b>Marital Status:</b> S   M   W   D		<b>Name of Spouse / Significant Other:</b>	
<b>Address Last Residence:</b> _____				Anniversary Date, if applicable: _____	
# of Children: _____		# of Living Children: _____		# Grandchildren: _____	
# Great Grandchildren: _____					
<b>Name(s) of Pets:</b> _____		<b>Type of Animal:</b> _____			
<b>PRIMARY LANGUAGE</b> English    Other (Specify) _____    Sign Language					
Other languages spoken: _____					
<b>Education:</b> Highest grade completed:    K-12 - Years _____ College - Years _____    Bachelors    Masters Doctoral			<b>Military Experience:</b> Branch: _____ Rank: _____		
<b>Work History:</b> Previous Occupation(s): _____					
Occupation resident identified with most: _____					
Specialized Training: _____					
Retirement/Most Recent Employment: _____					

### MEDICAL INFORMATION NEEDED FOR PLACEMENT

• History and Physical	• Chest X-Ray last 6 months <b>OR</b>	• TB Skin Test (PPD)
• Urinalysis	• CBC	• PAS 2000
• Copy of Advance Directives	• Copy of Legal Papers if applicable	
• Current Hospitalization Records if applicable: Nurse notes, medications, labs, treatments, consultations.		

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• Other: