

5101 Harrisburg Rd. Jonesboro, AR 72404

Craigheadnursingcenter.org

**Application for Admission**

Name of Applicant:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: \_\_\_M \_\_\_F Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_County:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Previous Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is applicant a Veteran and/or receives VA benefits: \_\_\_\_Yes \_\_\_\_No

Social Security # \_\_\_\_- \_\_\_\_- \_\_\_\_\_ Medicare # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medicaid # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Medical/Prescription Insurance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH INFORMATION**

Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last hospitalization: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hospital:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Pharmacy:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ambulance: \_\_\_Medic One \_\_\_Emerson

Has applicant fallen in the last (6) months? \_\_\_\_ Yes \_\_\_\_ No If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does applicant need assistance with:

Dressing: \_\_\_\_Yes \_\_\_\_No Bathing: \_\_\_\_ Yes \_\_\_\_ No Eating: \_\_\_\_ Yes \_\_\_\_ No

Does the applicant need any of the following \_\_\_\_Cane \_\_\_\_ Walker \_\_\_\_Wheelchair \_\_\_\_Assist with standing/walking

Does the applicant have a history of Dementia or Alzheimer’s disease? \_\_\_\_\_ Yes \_\_\_\_\_ No

Is the applicant oriented to \_\_\_\_person \_\_\_\_place \_\_\_\_time or \_\_\_\_Situation

List any nursing home stays in the last 5 years: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACTS**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home or cell

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Second Contact**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Home or cell

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL INFORMATION**

Religion:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Funeral Home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has applicant executed any Advanced Directives (i.e. Power of Attorney- healthcare/finances) \_\_\_\_\_Yes \_\_\_\_\_ No

If yes, please describe and list who the designated agent is:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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**FINANCIAL**

Does the applicant plan to apply for Long Term Care Medicaid? \_\_\_\_\_Yes \_\_\_\_\_ No

Has applicant ever applied for Medicaid in the past? \_\_\_\_Yes \_\_\_\_No

If yes, when: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was application \_\_\_\_\_ accepted \_\_\_\_\_ rejected

Has the applicant transferred any assets in the last 5 years? (this includes real estate, funds, personal property, etc)

\_\_\_\_Yes \_\_\_\_ No If yes, what assets were transferred and the value of items: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does applicant own their own home? \_\_\_\_\_Yes \_\_\_\_\_ No

If yes, address of the home: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the applicant have any life insurance policies? \_\_\_\_Yes \_\_\_\_ No

If yes, what is the cash surrender value of all policies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MONTHLY INCOME**

1. SOCIAL SECURITY $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. PENSION $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. ANNUITIES/TRUST $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. OTHER $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOTAL MONTHLY $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ x 12 MONTHS = $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ASSETS:**

1. STOCKS & BONDS $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. CHECKING/SAVINGS $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. REAL ESTATE $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. C.D.’s $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. OTHER $\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

There are funds to pay for care (less than 6 months) (\_\_\_\_ Months) (1 Year) (2 Years) (More than 2 years)

Person making application for admission:

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Craighead Nursing Center does not discriminate against anyone based on race, color, religion, sex, or national origin, age, sex, or handicap. Craighead Nursing Center is prohibited from admitting persons with physical or mental health problems that proper care cannot be provided.