

Responsible Parties in decision-making:

Name Address Tel.# (Home/Business/Cell) Relationship

Person to be notified in the event of illness:

ANY TIME day or night between 8AM & 10PM At time of death **ONLY**

Do all children know about this application? Yes No

Physician's Name: _____ Address: _____ Phone #: _____

Dentist's Name: _____ Address: _____ Phone #: _____

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

Other Income Source and Amount: _____

If there is no Medicaid Number for Chronic Care - copies of 60 months of financial information is 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 you do not indicate a preference above, the Tolstoy Foundation Rehabilitation & Nursing Center will call upon a local funeral home for holding in the event of death.*

- 1. I understand admission is based on medical need and therefore authorize Tolstoy Foundation Rehabilitation & Nursing Center 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.