FOREST HILLS RESIDENT APPLICATION

Admission Date: _____ Discharge Date:_____
(Facility fills out the above portion)

PERSONAL
Date:_____

Name: _____ Age: _____

D.O.B: _____ Social Security: _____

Medicare #: _____ Medicaid #: _____

Medicare Part D provider: _____ I.D: _____

Marital Status: _____ Religion: _____ Veteran: Y / N

Conservator of Applicant: _____ Phone #: _____

Address: _____

Conservator of Estate: _____ Phone #: _____

Address: _____

Responsible Person: _____ Phone #: _____

Relation: _____ Address: _____

Emergency Contact: _____ Phone #:_____

Relation: _____ Address: _____

Referred By: _____ Phone #:_____

Current living arrangements and address:

_____
_____
_____

Has applicant ever been convicted of a crime? Y / N
If Y, please detail below:

_____
_____

Does the applicant give permission to Forest Hills guest home to perform a background check for the purpose of this application? Y / N

Does the applicant:

Need assistance with bathing and dressing?	YES	NO
Have any infectious disease?	YES	NO
Display any inclination to wander?	YES	NO
Been diagnosed with a psychiatric illness?	YES	NO
Have a past or present history with alcohol or alcohol abuse?	YES	NO
Have any history with violent or inappropriate behavior?	YES	NO
Post any danger to themselves or others?	YES	NO

Use this area for explanation to any questions answered yes: _____

_____
_____
_____
_____

Special Dietary Requirements?: _____
_____

Allergies: _____

Routine:
Does the applicant smoke? Y / N Bedtime: _____ Wake time:_____

Hobbies or Interests: _____
_____
_____

FINANCIAL
(*Income source, amount and questionnaire for state applicants only*)

Social Security: _____ S.S.I _____ OTHER: _____
(Amount) (Amount) (Amount)

Does the applicant's current resources exceed $1600.00? Y / N

Does the applicant have a checking or savings account, trust fund, pre-paid funeral contract, life insurance policy or any other assets? _____
_____

Has the applicant sold or transferred any real estate, automobiles, or any other assets in the past 36 months? _____
_____

Has the applicant applied for state supplements with the Department of Social Services? (DSS) YES / NO

Dept. of Social Services Worker: _____ Phone #: _____

Medical
(Note: Medical and patient history sections of this application must be reviewed and signed by the applicants physician)

Date of most recent physical examination:_____ *Attach copy

Last PPD skin test and results: _____

Date of last flu shot: _____ Pneumonia Shot: _____

*Please attach a copy of immunization records with this application.

Current Height: _____ Current Weight: _____

Physicians Name: _____ *Ph #:* _____ *Field:*_____

Physicians Name: _____ *Ph #:* _____ *Field:*_____

Physicians Name: _____ *Ph #:* _____ *Field:*_____

Is the applicant…

Capable of self-administration of medication with supervision:	YES	NO
Continent of bowel and bladder?	YES	NO
Capable of reasonable understanding and direction?	YES	NO
Capable of using public transportation for medical appointments?	YES	NO

Diagnosis/Patient History:

_____
_____
_____
_____
_____

MEDICATIONS (Please indicate the reason the applicant is prescribed the medication listed below)

Name **Dosage**

1. _____
PRESCRIBED FOR: _____

2. _____
PRESCRIBED FOR: _____

3. _____
PRESCRIBED FOR: _____

4. _____
PRESCRIBED FOR: _____

5. _____
PRESCRIBED FOR: _____

6. _____
PRESCRIBED FOR: _____

7. _____
PRESCRIBED FOR: _____

I have reviewed the medical and patient history portions of this application.

Signed: _____ Date: _____
(Physician Signature)

The information contained in this “resident profile” application is accurate to the best of my knowledge. I understand that any misinterpretation of the applicants health, abilities or behavioral history may be grounds for discharge from this facility by the administrator.

Signed: _____ Date: _____

Signed: _____ Date: _____
Relation to applicant: _____