Lakeland Health Care Center

PRE-ADMISSION APPLICATION

General Information

Resident's Name: ____________________ Date: ____________________

Address: ____

____

Telephone: ____________________ Best Time to Contact: ____________________

Sex: ☐ Male ☐ Female Marital Status: __________ Birth Date: ____________

Health Concerns: ____

____

____

____

Currently ready for admission? ☐ Yes ☐ No Desire future admission? ☐ Yes ☐ No

Place of Worship: ____________________ Funeral Home: ____________________

Physician: ____________________ Dentist: ____________________

Eye Doctor: ____________________ Other Health Care Providers: ____________

Social Security No.: ____________________ Hospital Preference: ____________________

Past or present occupation(s): ____

Military (resident or spouse): ____

Have you ever been in another nursing home? ☐ Yes ☐ No If yes, please list the facility(ies) and dates of residencies?: ____

Please check all of the following that are appropriate (*Please provide the facility with a copy and complete Resident's Financial Representative Form. Resident will not be admitted without proper documentation on file*):

☐ Guardian

☐ Durable Power of Attorney ☐ Health Care ☐ Finances

☐ Other (living will, conservator, etc.)

Emergency Contacts:

1) Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________
Phone: ______________________________
e-mail: ______________________________
Relationship: __________________________

2) Name: ______________________________
Address: ______________________________
City, State, Zip: ______________________
Phone: ______________________________
e-mail: ______________________________
Relationship: __________________________

Insurance Information:

Medicare No.:__________________ Part A________________ Part B___________________

Medical Assistance No.: ___________________________ Effective Date: _________________

Prescription Drug Plan: ____

Long Term Care Insurance Company:____

Health Insurance Company: ____

Is this a Medicare supplement? ☐ Yes ☐ No Family Care participant? ☐ Yes ☐ No

Subscriber No.:____________________________________ Group No.: ___________________

Financial Information: *(Check one box: Assets listed below are available for…)*

☐ Individual seeking admission. OR ☐ Individual seeking admission and spouse living in the community.

Fixed Monthly Income:

Name of individual receiving fixed income (if other than resident): ________________________

Social Security/SSI	$_________________
Public Assistance Funds	$_________________
Pensions/Retirement	$_________________
Annuities or Trust Funds	$_________________
Maintenance (Spousal Support)	$_________________
Veteran Benefits	$_________________
Rents	$_________________
Other	$_________________

Please Specify: ____

TOTAL $________________

Monthly Income From Other Sources:

Dividends, Interest $ _______________________

Please Specify: ____

Other $_______________________

Please Specify: ____

Assets:

Stocks, Mutual Funds, Bonds	$ ___________________	Bank:___________________________
Savings Accounts, Checking	$___________________	Bank:___________________________
Certificates of Deposit	$___________________	Bank:___________________________
Real Estate	$___________________	
Life Insurance	$___________________	
Other (i.e. burial trust)	$___________________	

Please Specify: ____

TOTAL ASSETS $___________________

Person completing application:____

Relationship to Resident:____

Address: ____

Telephone: ____

Please return completed form to:
Admissions Coordinator, 1922 County Road NN, Elkhorn, WI 53121
Or fax to 262-741-3682
Lakeland Health Care Center