BROOKS-HOWELL

A retirement community that is called, served, and serving still

APPLICATION FOR HEALTH CENTER RESIDENCY

(Please print.)

☐ Respite Care | ☐ Skilled Nursing

DEMOGRAPHICS

Applicant legal name: _____

Address: _____

Telephone Number: (H) _____(C) _____

Email Address: _____Social Security Number: _____

Date of Birth: _____ Place of Birth: _____

Current or Previous Occupation: _____ Gender: ☐ Male | ☐ Female

Marital Status: ☐ Single | ☐ Widowed | ☐ Divorced | ☐ Married | Spouse Name: _____

Religion: _____ Are you an active member of a Church/Synagogue/Temple ☐ Yes | ☐ No

Name of Church: _____ Name of Clergy: _____

Would you like for your clergy to be updated? ☐ No | ☐ Yes – Phone Number: _____

Preferred Funeral Home: _____ Phone Number: _____

Served in Military: ☐ Yes | ☐ No Branch: _____ Rank: _____ Service Dates:_____

Tobacco Use: ☐ Yes | ☐ No (Brooks-Howell is a Tobacco-Free / Smoke-Free Community)

INSURANCE INFORMATION

Medicare # _____ Coverage: Part A ☐ Part B ☐ (provide front and back copies of cards)

Medicare Supplement: _____ Member ID #: _____ (provide copy of card)

Prescription Insurance : _____ Member ID #: _____ (provide copy of card)

Long Term Care Insurance: _____ Member ID #: _____ (provide copy of coverage)

CONTACTS:

Primary Contact (who to contact in an emergency) usually the HCPOA

Name: _____ Relationship: _____
Street Address: _____ City: _____State: _____ Zip: _____
Home: _____Cell: _____ Work: _____
Email: _____

Secondary Contact (different from the Primary Contact) – usually the Durable POA or Financial POA

Name: _____ Relationship: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home: _____Cell: _____ Work: _____
Email: _____

***Billing Contact* – Responsible for monthly statements**

Name: _____ Relationship: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home: _____Cell: _____ Work: _____
Email: _____

MEDICAL INFORMATION (Personal History)

Mental Status:	☐ Alert and Oriented | ☐ Has some memory loss | ☐ Has diagnosis of dementia
Vision:	☐ No problems | ☐ Wears Glasses | ☐ Cataracts | ☐ Glaucoma | ☐ Macular Degeneration
Hearing:	☐ No problems | ☐ Has Hearing Loss | ☐ Wears Hearing Aides - ☐ Left | ☐ Right | ☐ Both
Dental:	☐ No problems | ☐ Missing Teeth | ☐ Has Dentures | ☐ Has Partials | ☐ No Teeth
Skin Condition:	☐ No problems | ☐ Has skin concerns (describe): _____
Mobility:	☐ Walks without problem | ☐ Uses a cane | ☐ Uses a walker | ☐ Uses wheelchair
Toileting:	☐ Independent | ☐ Needs staff to help | ☐ Uses protective undergarments

Medications

Please attach a listing of all current medications, including all prescription medications and all over the counter medications. This list should include the following pieces of information;

1. The name of the medication, 2. The strength of the medication, 3. The amount you take at one time,
4. The number of times you take it each day and the times you take it, 5. The reason you take this medication.
This list is vital to ensuring we have the correct medications that you are currently taking

Allergies

Medications	Food/Environmental/Other

Immunization History

Last Flu Vaccine: Type: ☐ Standard | ☐ High Dose	Date of Pneumovax-23:	Date of Prevnar-13:
Date of Shingle Vaccine: Type: ☐ Shingrix | ☐ Zostavax	Date of Tdap:	Date of Last TB Skin Test: Result:

HEALTH CARE POWER OF ATTORNEY OR GUARDIANSHIP: Required to apply.

Applicant has a ☐ Health Care Power of Attorney or ☐ applicant has a Guardian. The Health Care Power of Attorney is _____. Relationship: _____. OR The Guardian is _____. Relationship: _____. Please attach the document to this application.

MEDICAL INFORMATION – Release Request

Living Situation: ☐ At Home | ☐ Healthcare Setting
Healthcare Center Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone Number: _____
Fax Number: _____

Primary MD Name: _____
Practice Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Office Number: _____
Fax Number: _____

Will this MD continue to follow you at Brooks-Howell? ☐ **Yes |** ☐ **No – will use Brooks-Howell MD.**

Specialist Name: _____
Type of Specialty: _____
Street Address: _____
City: _____ State: _____ Zip: _____
Office Number: _____
Fax Number: _____

Dentist: _____
Office Number: _____

Eye Doctor: _____
Office Number: _____

Podiatrist: _____
Office Number: _____

RELEASE OF INFORMATION:

I hereby authorize the release of my medical records from **the above healthcare providers** to be disclosed to Brooks-Howell Home as part of my Health Center residency application. **The information should be faxed to (828) 367-7978.** This release is to ensure continuity of care and treatment. I understand that the specific type of information to be disclosed includes:

H&P, Progress Notes, Immunization Records, Allergies, Labs, Cultures, Diagnostic Studies, Current Medication Listing, Medication Administration Records, Treatment Records, Consultations, Nurses Notes, Therapy Notes, Diagnosis Listing, Surgical Reports, and Discharge Summary.

Print Name: _____ Relationship to Resident: _____

Resident/Representative Signature_____ Date: _____

Witness Signature: _____Date:_____

I understand that as this applicant's health care needs change, there may be changes in this applicant's accommodations. Brooks Howell Home reserves the right to insure that the resident is moved to a room that meets the needs of the resident. I understand that Brooks-Howell is a Smoke-Free / Tobacco-Free Campus.

Please note that the admission process is a lengthy process. We request that the person responsible for the applicant's health care decisions be available to complete the necessary admission forms on the day of the admission.

I CERTIFY THAT THE INFORMATION CONTAINED IN THE APPLICATION IS ACCURATE AND COMPLETE.

_____ _____

Signature of Applicant / Applicant Representative Date

*Send completed application to:

Jill Knight, Admissions Coordinator
Telephone: 828-348-7270
266 Merrimon Avenue
Asheville, NC 28801

Fax: 828-367-7978
Email: jknight@brookshowell.org