



# *Magnolia Ridge*

*Residential Care and Assisted Living Facility*

*1007 Amherst Street, S.W.*

*Roanoke, Virginia 24015-2001*

*Phone: 540.342.8861*

*Fax: 540.343.3184*

*www.MagnoliaRidge.com*

## APPLICATION FOR ADMISSION

Applicant's Name \_\_\_\_\_

Current Address \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Name of Person Supplying Information \_\_\_\_\_

Relationship to Applicant \_\_\_\_\_

Person to Whom Information Should be Send \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_ Phone \_\_\_\_\_

Applicant's Previous Living Arrangements \_\_\_\_\_

Applicant's Present Living Arrangements \_\_\_\_\_

Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_ Marital Status \_\_\_\_\_

Birth date \_\_\_\_\_ Birthplace \_\_\_\_\_

Full Name of Spouse \_\_\_\_\_ Soc. Sec. No. of Spouse \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Names and Addresses of Living Children

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Previous Occupation of Applicant \_\_\_\_\_ Retirement Date \_\_\_\_\_

Hobbies and Special Interest of Applicant \_\_\_\_\_

Has Applicant ever served in the Armed Forces? \_\_\_\_\_ Which Branch? \_\_\_\_\_

Has Applicant ever been in a hospital?\_\_\_\_\_ Most Recent Admission Date\_\_\_\_\_

Reason for Admission\_\_\_\_\_ Last Discharge Date\_\_\_\_\_

Has Applicant ever been in a Nursing Home?\_\_\_\_ Name of Facility\_\_\_\_\_

Reason for Admission\_\_\_\_\_ Date of Admission\_\_\_\_ Date of Discharge\_\_\_\_\_

### IN CASE OF EMERGENCY NOTIFY

Responsible Party or Guardian:

Name / Relationship\_\_\_\_\_ Phone\_\_\_\_\_

Address\_\_\_\_\_ Zip Code\_\_\_\_\_

Others:

Name / Relationship\_\_\_\_\_ Phone\_\_\_\_\_

Address\_\_\_\_\_ Zip Code\_\_\_\_\_

Name / Relationship\_\_\_\_\_ Phone\_\_\_\_\_

Address\_\_\_\_\_ Zip Code\_\_\_\_\_

### INSURANCE INFORMATION

Does Applicant have coverage under Medicare?

Part A?\_\_\_\_\_ If yes, Number\_\_\_\_\_ Effective Date\_\_\_\_\_

Part B?\_\_\_\_\_ If yes, Number\_\_\_\_\_ Effective Date\_\_\_\_\_

Does Applicant have supplemental insurance coverage?

Company Name\_\_\_\_\_ Pre-Certification Phone Number\_\_\_\_\_

Policy Number\_\_\_\_\_ Group Number\_\_\_\_\_ Effective Date\_\_\_\_\_

### ADVANCED DIRECTIVES

Does Applicant have a Power of Attorney?\_\_\_\_\_ Name\_\_\_\_\_

Address\_\_\_\_\_ Phone\_\_\_\_\_

Is this person Power of Attorney for Financial?\_\_\_\_\_ Medical?\_\_\_\_\_

Does Applicant have a Do-Not-Resuscitate (DNR) Order?\_\_\_\_\_ A Living Will?\_\_\_\_\_

## ADDITIONAL DATA

Hospital Preference\_\_\_\_\_ Phone\_\_\_\_\_

Funeral Arrangements\_\_\_\_\_ Phone\_\_\_\_\_

Attending Physician\_\_\_\_\_ Phone\_\_\_\_\_

Address\_\_\_\_\_ Zip Code\_\_\_\_\_

Dentist\_\_\_\_\_ Phone\_\_\_\_\_

Address\_\_\_\_\_ Zip Code\_\_\_\_\_

Pastor\_\_\_\_\_ Phone\_\_\_\_\_

Address\_\_\_\_\_ Zip Code\_\_\_\_\_

Church\_\_\_\_\_ Phone\_\_\_\_\_

Address\_\_\_\_\_ Zip Code\_\_\_\_\_

Local Dept. of Social Services\_\_\_\_\_ Phone\_\_\_\_\_

Address\_\_\_\_\_ Zip Code\_\_\_\_\_

Caseworker\_\_\_\_\_ Phone\_\_\_\_\_

Address\_\_\_\_\_ Zip Code\_\_\_\_\_

## PHYSICAL CONDITION

Please list all Serious Illnesses within the last five years:

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Please check all that apply:

Dentures\_\_\_\_\_ Eyeglasses\_\_\_\_\_ Hearing Aid\_\_\_\_\_ Cane\_\_\_\_\_ Wheelchair\_\_\_\_\_

**Problems with:** Eyesight\_\_\_\_\_ Hearing\_\_\_\_\_ Heart Trouble\_\_\_\_\_ Epilepsy\_\_\_\_\_

Cancer\_\_\_\_\_ Tuberculosis\_\_\_\_\_ Diabetes\_\_\_\_\_ High Blood Pressure\_\_\_\_\_

Any Contagious Disease\_\_\_\_\_ Paralysis\_\_\_\_\_ Physical Deformity\_\_\_\_\_

Does the Applicant have any Drug Allergies?\_\_\_\_\_

Can the Applicant go to the bathroom without assistance?\_\_\_\_\_

Can the Applicant bathe without assistance?\_\_\_\_\_

Can the Applicant dress without assistance?\_\_\_\_\_

Does the Applicant take Medication?\_\_\_\_\_

Does the Applicant suffer confusion?\_\_\_\_\_

Does the Applicant wander?\_\_\_\_\_

Does the Applicant have any history of violence?\_\_\_\_\_

## CONFIDENTIAL FINANCIAL STATEMENT

### SOURCE OF INCOME — AMOUNT RECEIVED ANNUALLY

	Amount
1. Social Security	
2. Pension / Annuity	
3. Interest and Dividends	
4. Other Income (Please identify source)	
TOTAL	

Does Applicant Own Home?\_\_\_\_\_ Does Applicant Handle Own Finances?\_\_\_\_\_

**Please note:** Upon admission, please provide the following documents:

Social Security Card, Insurance Cards, POA/Guardianship Documents, Living Will, DNR Orders, History and Physical Report and Report of Tuberculosis Screening.

A non-refundable deposit equal to the amount of your monthly Room and Board rate along with this completed application will secure a room reservation for a period of thirty days.