OASIS

HEALTH AND REHABILITATION CENTER

APPLICATION FOR ADMISSION

NAME:_____ TELEPHONE #:_____

ADDRESS:_____
STREET CITY STATE ZIP CODE

DATE OF BIRTH:_____ U.S. CITIZEN: ☐ YES ☐ NO

SEX: M / F MARITAL STATUS: M / S / W / D / SEP NAME OF SPOUSE:_____

RELIGION:_____ HIGHEST LEVEL OF EDUCATION:_____

OCCUPATION:_____

YEAR RETIRED:_____ HOBBIES OR CLUB ASSOCIATIONS:_____

WERE YOU IN THE ARMED FORCES?_____ DATES:_____

FINANCIAL MANAGER

PLEASE STATE THE NAME(S) OF ANY PERSON(S) THAT HANDLE FINANCIAL MATTERS

NAME:_____ RELATIONSHIP:_____

ADDRESS:_____
STREET CITY STATE ZIP CODE

TELEPHONE:_____
HOME CELL WORK

IS THERE A POWER OF ATTY?_____
(PLEASE PROVIDE A COPY WITH THIS APPLICATION) NAME PHONE

PLEASE CHECK TYPE OF AUTHORITY: REPRESENTATIVE PAYEE ☐ CONSERVATOR ☐

LEGAL GUARDIAN ☐ DURABLE POWER OF ATTORNEY ☐

FUNERAL HOME:_____ TYPE: IRREVOCABLE TRUST/BANK ACCOUNT ☐ YES ☐ NO

NAME:_____ ADDRESS:_____ TELEPHONE #:_____

HEALTH CARE PROXY

PLEASE SUBMIT A COPY WITH THIS APPLICATION

NAME:_____ PHONE #:_____

RELATIONSHIP:_____ ADDRESS:_____
STREET CITY STATE ZIP CODE

IS THERE A LEGAL GUARDIAN? ☐ YES ☐ NO NAME:_____

SPOKESPERSON FOR THE APPLICANT

NAME:_____ PHONE #:_____

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EMERGENCY CONTACTS

NAME: _____ ADDRESS: _____
STREET CITY STATE ZIP CODE

RELATIONSHIP: _____ PHONE #: _____
HOME CELL

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RELATIONSHIP: _____ PHONE #: _____
HOME CELL

HEALTH INSURANCE AND INCOME

MEDICARE #: _____ PART A: ☐ PART B: ☐ PART D: ☐ A&B: ☐

OTHER HEALTH INSURANCE YOU MAY HAVE
(PLEASE PROVIDE A COPY WITH THIS APPLICATION)

NAME	POLICY NUMBER	$ MONTHLY or QUARTERLY
NAME	POLICY NUMBER	$ MONTHLY or QUARTERLY
NAME	POLICY NUMBER	$ MONTHLY or QUARTERLY

TYPE	RECIPIENT NAME	MONTHLY INCOME
SOCIAL SECURITY		
RETIREMENT (PENSION)		
VA PENSION		
RENTAL INCOME		
ANNUITIES		
OTHER (SPECIFY)		

PLEASE NOTE: IF YOU ARE APPLYING FOR . (MEDICAID), THE LOOK BACK PERIOD IS 5 (FIVE) YEARS. THIS IS TO DETERMINE WHETHER THERE HAVE BEEN ANY DISQUALIFYING ASSET TRANSFERS.

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BANK ACCOUNTS

BANK NAME	ACCOUNT #	NAMES ON THE ACCOUNT	TYPE	$ BALANCE
BANK NAME	ACCOUNT #	NAMES ON THE ACCOUNT	TYPE	$ BALANCE
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LIFE INSURANCE

COMPANY NAME	BENEFICIARY	POLICY #	FACE VALUE
COMPANY NAME	BENEFICIARY	POLICY #	FACE VALUE

CURRENT LIVING SITUATION

APPLICANT IS CURRENTLY LIVING AT: _____

DOES APPLICANT LIVE ALONE? ☐ YES ☐ NO WITH WHOM? _____

ADDRESS: _____

CONTACT PERSON: _____ TELEPHONE #: _____

PHYSICIAN: _____ TELEPHONE #: _____

DOES THE APPLICANT NEED HELP? EATING: ☐ BATHING: ☐ GETTING DRESSED: ☐
(PLEASE CHECK ALL THAT APPLY)

DOES THE APPLICANT WALK? INDEP: ☐ USE CANE: ☐ USE W/C: ☐
(PLEASE CHECK ALL THAT APPLY)

IS THE APPLICANT INCONTINENT? BLADDER: ☐ BOWEL: ☐
(PLEASE CHECK ALL THAT APPLY)

DOES THE APPLICANT HAVE MEMORY LOSS? ☐ YES ☐ NO ☐ SHORT TERM ☐ LONG TERM

HAS THE APPLICANT BEEN DIAGNOSED WITH ALZHEIMERS/DEMENTIA? ☐ YES ☐ NO

DOES THE APPLICANT HAVE ANY BEHAVIORS THAT ARE OF CONCERN? ☐ YES ☐ NO

_____

APPLICANT'S PHYSICIAN: _____ ADDRESS: _____

TELEPHONE #: _____

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LIST ANY RECENT HOSPITALIZATIONS

HOSPITAL: _____ APPROX DATE: _____

HOSPITAL: _____ APPROX DATE: _____

IF NOT HOSPITALIZED, PLEASE GIVE DATE OF LAST PHYSICAL EXAM: _____

HAS APPLICANT EVER RESIDED IN A NURSING HOME? ☐ YES ☐ NO

NAME: _____ ADDRESS: _____ DATE: _____

HAS APPLICANT EVER BEEN ADMITTED TO A STATE HOSPITAL OR PSYCHIATRIC UNIT? ☐ YES ☐ NO

NAME: _____ ADDRESS: _____ DATE: _____

ALCOHOL / TOBACCO USAGE

ALCOHOL USE:	☐ YES ☐ NO	TOBACCO USE:	☐ YES ☐ NO
PRESENT USE:	☐ YES ☐ NO	PRESENT USE:	☐ YES ☐ NO
PAST USE:	☐ YES ☐ NO	PAST USE:	☐ YES ☐ NO

HAS APPLICANT HAD TREATMENT FOR ALCOHOL ABUSE? ☐ YES ☐ NO

APPLICATION COMPLETED BY: _____

DATE: _____

PLEASE FEEL FREE TO EMAIL THIS APPLICATION TO: liaison@oasisrehabcare.net

ALL APPLICATIONS ARE KEPT ON FILE FOR 1 YEAR FROM DATE OF RECEIPT.