



Jones-Harrison
Established 1888

Honoring the full circle of life.

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Name _____
Last First Middle

Address _____
Street City State Zip

Previous Occupation _____

Home Phone (_____) _____ Date of Birth _____ / _____ / _____

Place of Birth _____

City State County
Marital Status: Single Married Divorced Widowed Gender: Male Female

Religion _____ Place of Worship _____

Clergy _____ Phone _____

Primary Physician

_____ Name Phone

_____ Address

Hospital Reference: _____

Describe current health status and history: (Why do you think you need placement?)

Have you ever lived in a nursing facility? Yes No *If yes, please give the name, address and dates you lived there:*

What type of room do you prefer? Private (additional cost) Semi-Private First Available

When are you looking for placement? Current 1-3 Months 6 Months

What type of 24-hour care do you need?

Transitional care 24-hour skilled care 24-hour skilled memory care

Insurance:

A. Primary

Policy Name _____
 _____ Policy Number _____ Phone _____

Address _____
 _____ Street _____ City _____ State _____ Zip _____

B. Secondary

Policy Name _____
 _____ Policy Number _____ Phone _____

Address _____
 _____ Street _____ City _____ State _____ Zip _____

Social Security Number _____

Medicare Number (*Include letter*) Part A effective date: _____

Part B effective date: _____

Private Pay or Medical Assistance Medical Assistance Number _____

Railroad Retirement Number _____ Veteran's Admin Number: _____

Send billing information to:

Name _____ Relationship _____

Address _____
 _____ Street _____ City _____ State _____ Zip _____

Home Phone (_____) _____ Work Phone (_____) _____

Do you have a: (*check one*) **Power of Attorney** **Conservator** or **Guardian**

List name, address, and phone number of above person and include a copy of this document:

Name _____ Relationship _____

Address _____

Home Phone (_____) _____ Work Phone (_____) _____

Do you have a health care directive? Yes No *If yes, please include a copy.*

Primary Contact *(local preferred)*

Name _____ Name _____

Address _____ Address _____

City _____ City _____

State/Zip _____ State/Zip _____

Relationship to Applicant _____ Relationship to Applicant _____

Home Phone _____ Home Phone _____

Work Phone _____ Work Phone _____

I understand that this application is necessary to be placed on the waiting list for admission to the Jones-Harrison Skilled Care Facility.

Being on the waiting list does not guarantee admission. Admission will be determined at the time of an opening when an assessment is completed by the Jones-Harrison Nursing and Social Services Departments.

By signing below, I am applying for admission to Jones-Harrison. The information contained in this application is correct and complete.

I agree that Jones-Harrison may contact my physician.

Signature of Applicant or Representative

Date