JONES-HARRISON
SENIOR LIVING

Skilled Care Admissions Application

RETURN TO: Jones-Harrison Assisted Living, 3700 Cedar Lake Ave., Minneapolis, MN 55416 *Application Received* _____

Name _____
Last First Middle

Address _____
Street City State Zip

Previous Occupation _____

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

Place of Birth _____
City State Country

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Biological Sex ☐ Male ☐ Female Gender Identity _____

Religion _____ Place of Worship _____

Clergy _____ Phone (_____) _____

Primary Physician's Name _____ Phone (_____) _____

Address _____
Street City State Zip

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? ☐ Immediately ☐ 1-3 Months ☐ 6 Months

INSURANCE

A. PRIMARY

Policy Name / Number _____ Phone (_____)_____

Address _____
Street City State Zip

B. SECONDARY

Policy Name / 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

Email _____ Phone (_____) _____

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

List names, address, and phone number of above person and include a copy of this document.

Name _____ Relationship _____

Address _____
Street City State Zip

Email _____ Phone (_____) _____

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

PRIMARY CONTACT (local preferred)

Name _____

Address _____

City _____

State / Zip _____

Email _____

Relationship to Applicant _____

Phone (_____) _____

Name _____

Address _____

City _____

State / Zip _____

Email _____

Relationship to Applicant _____

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*

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