

ADMISSION APPLICATION



Jones-Harrison
Established 1888

Date of Application In: _____

Name: _____
Last First Middle

Address: _____
Street City State Zip

Previous Occupation: _____

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

Place of Birth: _____
City State County

Marital Status: Single Married Divorced Widowed

Biological Sex: Male Female Gender Identity: _____

Religion: _____ Place of Worship: _____

Clergy: _____ Phone: (_____) _____

Primary Physicians 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: _____

Email: _____ Phone: (_____) _____

Do you have a health care director: Yes No *If yes please include a copy.*

PRIMARY CONTACT (*local preferred*):

Name: _____

Name: _____

Address: _____

Address: _____

City: _____

City: _____

State/Zip: _____

State/Zip: _____

Email: _____

Email: _____

Relationship to Applicant: _____

Relationship to Applicant: _____

Phone: (_____) _____

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