Lakeland Health Care Center

PRE-ADMISSION APPLICATION

General Information

Resident's Name: ___________________________________ Date: __________________________

Address: ____

____

Telephone: _____________________ Best Time to Contact: _________________________

Sex: ☐ Male ☐ Female Marital Status: __________ Birth Date: _______________

Health Concerns: ____

____

____

____

Currently ready for admission? ☐ Yes ☐ No Desire future admission? ☐ Yes ☐ No

Religious Preference: __________________________ Funeral Home: _______________________

Physician: ____________________________ Dentist: ___________________________________

Eye Doctor: ___________________________ Other Health Care Providers: ________________

Social Security No.: ____________________ Hospital Preference: ________________________

Past or present occupation(s): ____

Military (resident or spouse): ____

Have you ever been in another nursing home? ☐ Yes ☐ No If yes, please list the facility(ies) and dates of residencies?: ____

Please check all of the following that are appropriate (*Please provide the facility with a copy and complete Resident's Financial Representative Form. Resident will not be admitted without proper documentation on file*):

☐ Guardianship

Durable Power of Attorney: ☐ POA Health Care ☐ POA Finances

☐ Other (Living will, conservator, etc.)

Emergency Contacts:

1) Name: ______________________________
Address:______________________________
City, State, Zip: _______________________
Phone: _______________________________
e-mail: ______________________________
Relationship: __________________________

2) Name: ____________________________
Address: ____________________________
City, State, Zip: _____________________
Phone: _____________________________
e-mail: _____________________________
Relationship: ________________________

Insurance Information:

Medicare No.:__________________ Part A________________ Part B____________________
Medical Assistance No.: ____________________________ Effective Date: _________________
Prescription Drug Plan: ____
Long Term Care Insurance Company:____
Health Insurance Company: ____
Is this a Medicare supplement? ☐ Yes ☐ No Family Care participant? ☐ Yes ☐ No
Subscriber No.:____________________________________ Group No.: ___________________

Financial Information: *(Check one box: Assets listed below are available for…)*

☐ Individual seeking admission. OR ☐ Individual seeking admission and spouse living in the community.

Fixed Monthly Income:
Name of individual receiving fixed income (if other than resident): ________________________

Social Security/SSI $_________________
Public Assistance Funds $_________________
Pensions/Retirement $_________________
Annuities or Trust Funds $_________________
Maintenance (Spousal Support) $_________________
Veteran Benefits $_________________
Rents $_________________
Other $_________________
Please Specify: ____

TOTAL $________________

Monthly Income From Other Sources:
Dividends, Interest $ _______________________
Please Specify: ____
Other $_______________________

Please Specify: ____

Assets:

Stocks, Mutual Funds, Bonds	$ __________________	Bank:__________________________
Savings Accounts, Checking	$__________________	Bank:__________________________
Certificates of Deposit	$__________________	Bank:__________________________
Real Estate	$__________________	
Life Insurance	$__________________	
Other (i.e. burial trust)	$__________________	

Please Specify: ____

TOTAL ASSETS $__________________

Person completing application:____

Relationship to Resident:____

Address: ____

Telephone: ____

Additional notes or comments:

Please return completed form to:
Admissions Coordinator, 1922 County Road NN, Elkhorn, WI 53121
Or fax to 262-741-3682
Lakeland Health Care Center