



BROOKS-HOWELL

A retirement community that is called, served, and serving still

APPLICATION FOR HEALTH CENTER RESIDENCY

Respite Care | Intermediate Care | Skilled Nursing

Demographics

Applicant legal name: _____

Address: _____

Telephone Number: (H) _____ (C) _____

Email Address: _____ Social Security Number: _____

Date of Birth: _____ Place of Birth: _____

Current or Previous Occupation: _____ Gender: Male | Female

Marital Status: Single | Widowed | Divorced | Married | Spouse Name: _____

Religion: _____ Are you an active member of a Church/Synagogue/Temple Yes | No

Name of Church: _____ Name of Clergy: _____

Would you like for your clergy to be updated? No | Yes – Phone Number: _____

Preferred Funeral Home: _____ Phone Number: _____

Served in Military: Yes | No Branch: _____ Rank: _____ Service Dates: _____

Tobacco Use: Yes | No (Brooks-Howell is a Tobacco-Free / Smoke-Free Community)

INSURANCE INFORMATION

Medicare # _____ Coverage: Part A Part B (provide copy of card)

Medicare Supplement: _____ Member ID #: _____ (provide copy of card)

Prescription Insurance: _____ Member ID #: _____ (provide copy of card)

Long Term Care Insurance: _____ Member ID #: _____ (provide copy of coverage)

Contact List:

Primary Contact (who to contact in an emergency) usually the HCPOA

Name: _____ Relationship: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____
Email: _____

Secondary Contact – usually the Durable POA or Financial POA

Name: _____ Relationship: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____
Email: _____

BILLING CONTACT – Responsible for monthly statements

Name: _____ Relationship: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home: _____ Cell: _____ Work: _____
Email: _____

Medical Information (Personal History)

Mental Status:	<input type="checkbox"/> Alert and Oriented <input type="checkbox"/> Has some memory loss <input type="checkbox"/> Has diagnosis of dementia
Vision:	<input type="checkbox"/> No problems <input type="checkbox"/> Wears Glasses <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Macular Degeneration
Hearing:	<input type="checkbox"/> No problems <input type="checkbox"/> Has Hearing Loss <input type="checkbox"/> Wears Hearing Aides - <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Both
Dental:	<input type="checkbox"/> No problems <input type="checkbox"/> Missing Teeth <input type="checkbox"/> Has Dentures <input type="checkbox"/> Has Partials <input type="checkbox"/> No Teeth
Skin Condition:	<input type="checkbox"/> No problems <input type="checkbox"/> Has skin concerns (describe): _____
Mobility:	<input type="checkbox"/> Walks without problem <input type="checkbox"/> Uses a cane <input type="checkbox"/> Uses a walker <input type="checkbox"/> Uses wheelchair
Toileting:	<input type="checkbox"/> Independent <input type="checkbox"/> Needs staff to help <input type="checkbox"/> Uses protective undergarments

****Medications****

Please attach a listing of all current medications being taken, include all prescription medications and all over the counter medications. This list should include the following pieces of information;

1. The name of the medication, 2. The strength of the medication, 3. The amount you take at one time,
4. The number of times you take it each day, and the times you take it, 5. The reason you take this medication.

This list is vital to ensuring we have the correct medications that you are currently taking

Allergies

Medications	Food/Environmental/Other

Immunization History

Last Flu Vaccine: Type: <input type="checkbox"/> Standard <input type="checkbox"/> High Dose	Date of Pneumovax-23:	Date of Prevnar-13:
Date of Shingle Vaccine: Type: <input type="checkbox"/> Shingrix <input type="checkbox"/> Zostavax	Date of Tdap:	Date of Last TB Skin Test: Result:

MEDICAL INFORMATION – Release Request

Living Situation: At Home | Healthcare Setting
Street Address: _____
Phone Number: _____

Healthcare Center Name: _____
City: _____ State: _____ Zip: _____
Fax Number: _____

Primary MD Name: _____
Street Address: _____
Office Number: _____

Practice Name: _____
City: _____ State: _____ Zip: _____
Fax Number: _____

Will this MD continue to follow you at Brooks-Howell?

Yes | **No – will use Brooks-Howell MD**

Specialist Name: _____
Street Address: _____
Office Number: _____

Type of Specialty: _____
City: _____ State: _____ Zip: _____
Fax Number: _____

Dentist: _____

Office Number: _____

Eye Doctor: _____

Office Number: _____

Podiatrist: _____

Office Number: _____

Release of Information:

I hereby authorize the release of my medical records from **the above healthcare providers** to be disclosed to Brooks-Howell Home as part of my Health Center residency application. **The information should be faxed to (828) 367-7978.** This release is to ensure continuity of care and treatment. I understand that the specific type of information to be disclosed includes:

H&P, Progress Notes, Immunization Records, Allergies, Labs, Cultures, Diagnostic Studies, Current Medication Listing, Medication Administration Records, Treatment Records, Consultations, Nurses Notes, Therapy Notes, Diagnosis Listing, Surgical Reports, and Discharge Summary.

Print Name: _____ Relationship to Resident: _____

Resident/Representative Signature _____ Date: _____

Witness Signature: _____ Date: _____

I understand that as this applicant's health care needs change, there may be changes in this applicant's accommodations. Brooks Howell Home reserves the right to insure that the resident is moved to a room that meets the needs of the resident. I understand that Brooks-Howell is a Smoke-Free / Tobacco-Free Campus.

Please note that the admission process is a lengthy process. We request that the person responsible for the applicant's health care decisions be available to complete the necessary admission forms on the day of the admission.

I CERTIFY THAT THE INFORMATION CONTAINED IN THE APPLICATION IS ACCURATE AND COMPLETE.

Signature of Applicant / Applicant Representative

Date

*Send completed application to:

Jill Knight, Admissions Coordinator

Telephone: 828-253-6712

266 Merrimon Avenue

Asheville, NC 28801

Fax: 828-367-7978

Email: jknight@brookshowell.org

