



# BROOKS-HOWELL

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

## APPLICATION FOR HEALTH CENTER RESIDENCY

(Please print.)

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 front and back copies of cards)

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)

**CONTACTS:**

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

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

**Secondary Contact (different from the Primary 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:

**HEALTH CARE POWER OF ATTORNEY OR GUARDIANSHIP: Required to apply.**

Applicant has a  Health Care Power of Attorney or  applicant has a Guardian. The Health Care Power of Attorney is \_\_\_\_\_. Relationship: \_\_\_\_\_. OR The Guardian is \_\_\_\_\_. Relationship: \_\_\_\_\_. Please attach the document to this application.

**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: 828-348-7270  
266 Merrimon Avenue  
Asheville, NC 28801

Fax: 828-367-7978  
Email: [jknight@brookshowell.org](mailto:jknight@brookshowell.org)

