**APPLICATION FOR PROSPECTIVE ADMISSION**

**Applicant's Name (prospective resident)**: ___________________________________

**Current Address:** __________________________________________________________

**Phone Number**: ___________________________________________________________

**Is applicant or applicant's spouse a wartime Veteran?** YES NO

**Is applicant currently enrolled with ContinuUs or other Family Care?** YES NO

**Marital Status:** __________________ **Former Occupation**: ______________________

**Birth Date:** ______________________ **Social Security Number:** __________________

## HEALTH INFORMATION

**What activities of daily living does the applicant need assistance with?**
Examples include: bathing and dressing assistance, medication management and administration, help transferring to and from chair or bed, assistance walking, etc.

___________________________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

**Current Health Conditions or Medical Diagnosis:** ____________________________

___________________________________________________________________________

**Allergies:** Drug: _________________ Food: _______________ Contact: ____________

**Primary Physician:** __________________________ **Clinic:** _______________________

**Other Physicians (i.e. cardiologist, pulmonologist, endocrinologist):**

(Name)____________________________________ Clinic: ____________________

(Name)____________________________________ Clinic: ____________________

(Name)____________________________________ Clinic: ____________________

**Podiatrist:** ______________________________ **Clinic:** __________________________

**Dentist:** __________________________________________________________________

**Optometrist:** _______________________________________________________________

**Hospital Preference:** ________________________________________________________

**Pharmacy:** _________________________________________________________________

**Funeral Home Preference:** ___________________________________________________

**Power of Attorney (POA) for Finances and or Healthcare:**

| Name | Address | Phone |
|---|---|---|
| | | |

| Name | Address | Phone |
|---|---|---|
| | | |

**Is applicant's POA-Healthcare activated?** YES NO

**Has applicant completed Advanced Directives/Living Will document:** YES NO

I authorize the notification of the following individuals in the case of an emergency or to receive and review information on my health and care**:**

| Name | Address | Phone |
|---|---|---|
| | | |

| Name | Address | Phone |
|---|---|---|
| | | |

## FINANCIAL INFORMATION

**(ContinuUs Family Care Members: Skip this box.)**

Financial information provided is kept confidential. However, a current bank statement must be furnished in order to provide verification. Currently, there is limited public funding for assisted living care. Please indicate the duration that residency could be maintained with private funds:

0-6 months____ 6 months to 1 year____ 1-2 years____ 2-3 years_____ 3+years____

Would applicant be handling his/her own financial matters, or would invoices need to be sent to a different address?

| Name | Address | Phone |
|---|---|---|
| | | |

I declare that the information contained herein is true and complete to the best of my knowledge. I give consent to Wolftever Healthcare LLC DBA/Rutledge Home to verify any information contained therein and receive a copy of my most recent history and physical and medication list from my primary physician. I understand that this information is confidential and will be relied upon to determine the status of this application for admission.

______________________________ ______________

Prospective Resident's Name / Signature Date

______________________________ ______________

Responsible Party Name / Signature Date