Braley Care Homes
Where Caring Is Our Business

RESIDENT APPLICATION

DATE: ____/____/____

GENERAL INFORMATION ***(Please Print)***

Name: _____ Gender: Male ___ Female ____Age: _____

Address:_____

_____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Place of Birth: _____ Marital Status: _____

Spouse's Name: _____ SSN #: _____-_____-_____

No. of Living Children: _____

Religious Affiliation: _____ Name of Church:_____

Address:_____Telephone No._____

Name of Pastor: _____ Telephone No._____

Hobbies and Interests: (a brief description interests past and present will aid in creating activities for resident).

_____

_____

HISTORY:

Occupation: _____

Clubs or organizations: _____

PRESENT PHYSICIAN

Doctor:_____ Telephone No. _____

Address:_____

Doctor:_____ Telephone No. _____

Address:_____

Psychiatrist (if applicable)_____Telephone No. _____

Address:_____

Dentist(if applicable)_____Telephone No._____

Address: _____

Does this applicant have future Doctor's appointments we should know about? ___Yes ___No

If yes please give date and time and which physician,

_____

_____

MEDICAL INFORMATION:

Allergies (*if known*)_____

Is this applicant currently confined in a hospital or nursing home?_____

If so, where?_____

For what reason? _____

List of Medications: _____

_____

_____

PRESENT PHYSICAL CONDITION

Resident's Present Diagnosis: primary_____

secondary:_____other: _____

Has there been a drastic weight loss? _____ Yes _____No

Does Resident have Dentures:_____ Upper _____ Lower _____Full?

Does Resident have control of Bowels: _____ Yes _____ No Bladder: _____ Yes _____ No

Does Resident have any self-managing colostomies, urostomies or catheters: _____

Frequent Diarrhea?_____ Constipation? _____

Is there any other medical information Braley Care Homes should know about this resident?

_____

_____

Does the resident have a Do Not Resuscitate Order ___Yes ___No

PSYCHOLOGICAL

Does resident communicate clearly? __ Yes __ No Is the resident ____ Alert ____ Confused

How does resident feel about receiving in-home services? _____

_____

How does Resident spend their time?_____

_____

Does Resident seem to be:

Depressed _____ Angry_____ Cheerful_____ Fearful _____ Content _____

Confused _____ Combative_____ Does the resident wander? ___ Yes ___ No

OTHER INFORMATION

Responsible party to be notified in case of an emergency, discharge or demise of the resident:

Name:_____ Relationship:_____

Address_____ Telephone No._____

Name:_____ Relationship:_____

Address_____ Telephone No._____

Does Resident have legal representation?_____

Check if applicant has any of the following:

___Guardian -Name, address, phone_____

___ Medical Power of Attorney –Name, address, phone _____

___ Power of Attorney- Name, address, phone _____

___ Durable Power of Attorney- Name, address, phone_____

___Living Will ___ Resuscitation Directives

List any person, agency, or organization responsible for payments for support of the Resident:

_____

_____

DIRECTIONS

_____

_____

_____

INSURANCE INFORMATION

Primary Insurance _____ Address:_____

Policy #:_____ Group #:_____

Secondary Insurance _____ Address:_____

Policy #:_____ Group #:_____