WESTWIND MANOR *Assisted Living*

25 Main Street
Franklin, New Jersey 07416
973.827.6575
westwindmanor.com

Information Regarding Resident Applicant

Resident's Name____Male____Female____

Home Address____

City/Town____________________________________County_____________State______Zip___________

Phone#(s) Home____________________Mobile___________________Email______________________

Date of Birth (DOB) ______________________Social Security No. (SSN)___________________________

Marital Status Single________Married_________Divorced_________Widowed____________________

Current Location: Home ____Asst'd Living____Rehab/Nursing Facility____Other____How Long________

If Other, Please Specify——————————————————————————————

Name, Address & Phone of Current Location____

____

Birthplace____US Citizen* (Y/N)____________

Language(s) Spoken &Understood- Primary __________________Other(s)____________________________

Work Status Employed______Self-Employed______Unemployed______On Disability______Retired_____

Former Major Occupation(s) & Length of Time(s)____

____

Highest Level of Education___________________________________Year of Diploma/Degree_____________

Religion (Y/N) _____If Yes, please provide name, location &contact of church/synagogue/temple/mosque.

____

Hospital Preference ____

Room Preference Private/Single_______Semi-Private/Double______

Smoker** (Y/N) _____

*If born outside the US, please be prepared to provide citizenship papers.
**Westwind Manor is a smoke-free facility.

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Information Regarding Resident Applicant cont'd

Contact/Notification Information in case of Emergency

Name ____Relationship____________________
Address ____
City/Town____State______Zip________________
Phone(s) Home _____________________Mobile_____________________Work________________________
Preferred Order of Emergency Contact ____
Email (s)____
Occupation____

Other Relative(s) NOT listed above

1. Name ____Relationship________________
   Address ____
   City/Town____State________Zip________________
   Phone(s) Home _____________________Mobile_____________________Work___________________
   Preferred Order of Emergency Contact ____
   Email (s)____
   Occupation____
2. Name ____Relationship________________
   Address ____
   City/Town____State________Zip________________
   Phone(s) Home _____________________Mobile_____________________Work___________________
   Preferred Order of Emergency Contact ____
   Email (s)____
   Occupation____

Is resident applicant aware of this application and in agreement with placement? Yes__ No___
Can resident applicant be contacted regarding the statue of this application? Yes_____No______
Does applicant have an advance directive and/or DNR order in place?* Yes_____No______
Does applicant have designated medical and financial decision Power of Attorneys?* Yes_____No______

Medical &Durable Power of Attorney (POA)

Name____Relationship_________________________
Address____
City/Town____State________Zip_________________

Existing Funeral Arrangements? Yes_____No______

If Yes, Name, Address & Phone of Funeral Home____
____

Organ Donor? Yes*_____No_____

*copies required of Advance Directive, DNR, Medical/Durable Powers of Attorney and Organ Donor Card

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Information Regarding Resident Applicant cont'd

Financial

Will resident applicant pay for residency with his/her own funds? Yes_____No______

Does applicant own a home? Yes_____No______

If yes, specify location's address and property block & number____

____

____

Please name individuals currently residing at applicant's home including relationship to applicant._____________

____

____

If not a home owner, has applicant owned a home within last 10 years? Yes_____No______

If yes, what was the disposition of the home & property?____

____

Does applicant own any other property? Yes_____No______

If yes, identify/describe property(ies) and location(s)____

____

____

Are any of the above listed properties currently for sale? Yes_____No______

If yes, will proceeds from sale be used to pay for applicant's care? Yes_____No______

Financial Guarantor (party responsible for making payments on behalf of applicant)

Name ____Relationship____________________

Designated Durable Power of Attorney? Yes_____No_____

Address ____

City/Town____State________Zip________________

Phone(s) Home _______________________Mobile_____________________Work________________________

Preferred Order of Contact ____

Email (s)____

Occupation/Business/Firm____

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Health Insurance

Does resident applicant have traditional Medicare? Yes____No____ Medicare ID#____________________

Does applicant have a Medicare HMO? (eg. Advantage) Yes____No____ HMO Policy#____________________
Name of Medicare HMO _____________________________________Effective Date_______________

Does applicant have a Medicare Prescription Plan? Yes____No____

Does applicant have PAAD or Senior Gold? Yes____No____ PAAD/Sr Gold ID#______________

Does applicant supplemental health insurance? Yes____No____ Suppl Policy#___________________

Name & Address of Supplemental Health Insurance Co____

____

____

Supplemental Coverage is for (check each that apply)

Medical _____Dental_____ Eye____Hearing______Prescriptions_______

Other Insurances or Assistance

Does applicant have Medicaid or Public Assistance? Yes____No_____
If Yes, Medicaid ID#____________________________ Effective Date_______________

If No, has an application for Medicaid been submitted for the applicant? Yes____No____
If Yes, Date of Application _______________Case Manager's Name _____________________________
Phone #__________________District application was filed in_________________________________

Does the applicant have Long Term Care Insurance(s) Yes____No_____

If Yes, Name & Address of Insurance Co(s)____

____

____

Policy / ID #(s) ____

____

Does applicant have Life Insurance(s)? Yes____No_____

If Yes, Name & Address of Insurance Co(s)____

____

____

Policy #(s) ____

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Information Regarding Resident Applicant cont'd

Medical Information/History

A. Current Health Issues/Diagnoses

	Diagnosis/Medical Condition	Date of Onset
1.	______________________________	__________
2.	______________________________	__________
3.	______________________________	__________
4.	______________________________	__________
5.	______________________________	__________
6.	______________________________	__________
7.	______________________________	__________
8.	______________________________	__________

B. Current Medications

	Name of Medication	Dosage	Frequency	Treatment for
1.	______________________________			__________
2.	______________________________			__________
3.	______________________________			__________
4.	______________________________			__________
5.	______________________________			__________
6.	______________________________			__________
7.	______________________________			__________
8.	______________________________			__________

C. Hospital/Medical Facility Stays in the Past Year (i.e. nursing, rehabilitation, psychiatric, acute/emergency care, etc)

	Name of Facility	Date & Length of Stay
1.	______________________________	__________
2.	______________________________	__________
3.	______________________________	__________
4.	______________________________	__________
5.	______________________________	__________
6.	______________________________	__________

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Information Regarding Resident Applicant cont'd

Medical Information/History (cont'd)

D. Resident Applicant's Physicians (Please list all i.e. oncologist, psychiatrist, podiatrist, cardiologist, etc.)
NOTE: Please identify primary physician with asterisk next to physician's name.

	Physician's Name	Specialty	Phn#	Fax#
1.	____________________________	_______________	___________________	__________________
2.	____________________________	_______________	___________________	__________________
3.	____________________________	_______________	___________________	__________________
4.	____________________________	_______________	___________________	__________________
5.	____________________________	_______________	___________________	__________________
6.	____________________________	_______________	___________________	__________________

E. Applicant's Special Care Needs

Grooms Self? Yes_____No_____ Dresses Self ? Yes_____No_____
Special Diet Needed? Yes_____No_____ If Yes, specify ___________________________
Bed-Bound? Yes_____No_____ Mobility Assistance? Yes_____No_____
If mobility assistance is required, what assistance equipment will be brought with applicant?
(i.e. walker, cane, wheelchair, etc.) ____
Incontinent? Yes____No_____ Catheter? Yes_____No_____
Uses Oxygen? Yes____No_____ Wears Hearing Aid(s) Yes_____No_____
If Yes, specify which ear(s) & date last exam_______________________
Wears glasses? Yes____No_____ If Yes, date last exam____________________
Wears dentures? Yes____No_____ If Yes, specify (i.e. partial, full, implant. etc.)
& date last exam____
Has allergy(ies)? Yes____No_____ If Yes, specify (i.e. medication, food, latex,
antibiotic, pollen, etc.)____
Sees Podiatrist? Yes____No_____ If Yes, date last exam____________________

F. Applicant's Mental Status Note: clinical documentation copies required prior to admission

Is Alert? Yes___ No____ Confused? Yes____No_____
Quiet & Controlled? Yes____No_____ Depressed/Withdrawn? Yes____No_____
Wanders? Yes____No_____ Temper Outbursts? Yes____No_____
Crying episodes? Yes____No_____ Screaming Episodes? Yes____No_____
Yelling episodes? Yes____No_____ Enjoys Conversation? Yes____No_____
Enjoys Activities? Yes___ No_____ Specify ________________________________

Gets out of bed, dressed & groomed daily? Yes____No_____ If No, explain_______
____
Examined/evaluated for any memory issues (i.e. loss, dementia, Alzheimer's)? Yes____No_____
If Yes, explain diagnosis &date of exam/evaluation ____
____
Other significant events/occurrences recalled about applicant's mental abilities? Yes____No_____
If Yes, specify____