Application for Admission - Trego County Lemke Memorial Hospital

_____ **Long Term Care** _____ **Assisted Living (please mark one)**

Date: _____

Name of Potential Resident: _____

How soon is a room needed? ☐ Immediately ☐ When a room opens up
☐ Unsure - would like to be placed on list

Referral Source: ☐ Hospital ☐ Doctor's Office ☐ Other SNF/Senior Living Facility
☐ Family Member ☐ Other:_____

Medical Information and Needs

Primary Physician: _____

Reason for admission: _____

Additional Care Needs: _____

_____

Does potential resident currently receive any home care services: ☐ Yes ☐ No

If yes, what services are being provided: _____

_____

Has the potential resident had / anticipate to have a qualifying hospital stay? ☐ Yes ☐ No

Date of admission to hospital and where? _____

Has potential resident completed a CARE Assessment with the Area on Aging? ☐ Yes ☐ No

If yes, when? _____

Does potential resident plan to discharge? (ex: stay is required during recovery from surgery or injury)

☐ Yes ☐ No Explain: _____

LTC applicant only

Medicare Number: _____

Medicaid Number: _____

Other Insurance: _____

Will potential resident be private pay? ☐ Yes ☐ No

If Yes, please complete the following:

Checking/Savings/Cd balance: _____

Life Insurance cash value: _____

Annuities/pension/retirement plan value: _____

Other monthly income: _____

Own home? _____ Own other property? _____

Contact Information:

Name and relationship: _____

Phone: _____ Address: _____

I (we) make this application for residence of my (our) own free will and accord. I (we) declare the information provided to be true, complete and an accurate financial account to the best of my (our) knowledge at time of completion.

Signature: _____