CUYUNA REGIONAL MEDICAL CENTER
320 East Main St. Crosby, MN 56441 218-546-7031

APPLICATION FOR CARE CENTER ADMISSION

RESIDENT INFORMATION

Residents Name: _____
First Middle Last Maiden

Preferred Name: _____ Social Security Number: _____
Address: _____ Phone Number: _____
_____ Date of Birth: _____
_____ Place of Birth: _____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

EMERGENCY CONTACTS

☐ **Invite to care conference**	☐ **Invite to care conference**	☐ **Invite to care conference**
1. Name: _____	2. Name: _____	3.Name: _____
Relationship: _____	Relationship: _____	Relationship: _____
Address: _____	Address: _____	Address: _____
_____	_____	_____
Home Phone: _____	Home Phone: _____	Home Phone: _____
Work Phone: _____	Work Phone: _____	Work Phone: _____
Cellular (optional): _____	Cellular (optional): _____	Cellular (optional): _____

SERVICE PROVIDERS

Attending Physician: _____ Attending Dentist: _____
Ophthalmologist/Optometrist _____ Funeral Home Preference: _____
Home Health Care Agency _____ Upcoming Appointments _____

FINANCIAL

Person Managing Finances for Resident: _____
Payment Source for Nursing Home:
☐ Medicare
Medicare #: _____
☐ Medical Assistance (MA)
MA #: _____

☐ Private Insurance
Company: _____
Group # _____
ID# _____
☐ Private Funds

Pharmacy Preference: Guidepoint

LEGAL OVERSIGHT/DIRECTIVES

I would like my name and room number included in the resident roster in the front lobby: ☐ Yes ☐ No

☐ Financial Power of Attorney ☐ Health Care Power of Attorney/Agent ☐ Conservator/Guardian ☐ Living Will

_____ _____ _____

DAILY ROUTINES

Does the applicant . . .

currently live alone? . . . . . ☐ Yes ☐ No ☐ In other facility
adjust easily to change? . . . . . ☐ Yes ☐ No
have a history of insomnia? . . . . . ☐ Yes ☐ No Usual Bed Time: _____
seem unpleasant in the morning? . . . . . ☐ Yes ☐ No
take naps? . . . . . ☐ Yes ☐ No
have snacks between meals? . . . . . ☐ Yes ☐ No Preference: _____
have a history of:
Nursing Home Placement? . . . . . ☐ Yes ☐ No If so, when? _____
Mental Illness? . . . . . ☐ Yes ☐ No
Mental Retardation? . . . . . ☐ Yes ☐ No
Chemical Dependency? . . . . . ☐ Yes ☐ No

☐ Shower or ☐ Bath Preference? Time of day for shower or bath: _____

Toileting Needs (example: does the applicant get up at night?): _____

Please describe the applicant's daily attire: _____

Frequency of activity outside the home: ☐ Daily ☐ Weekly ☐ Monthly

Type of activity outside the home: _____

Hobbies/Group Activities: _____

Pets: _____

SOCIAL HISTORY

Does the applicant vote in political elections? ☐ Yes ☐ No

Education: _____ Military Service: _____
(Branch & years if known)

Previous Occupation: _____ Retirement Date: _____

Religion/Spiritual Needs: _____ Church Affiliation: _____

Significant Life Experience: _____

Name of Spouse: _____
(Past/Present – Living or Deceased)

Date of Marriage: _____ Date of Death/Divorce of spouse: _____
(Mo./Date/Year) (Mo./Date/Year)

Name of Parents: _____
(Living or Deceased/Include Mother's Maiden Name)

Number of Brothers Living _____ Deceased _____
Number of Sisters Living _____ Deceased _____
Number of Children Living _____ Deceased _____

Anticipated discharge plans: _____

Please rate the resident's general feelings toward nursing home placement, his/her health status, adjustment , etc.

Anxiety:	Extremely Anxious	1	2	3	4	5	Calm, peaceful
Depression/Sadness:	Very Sad, Depressed	1	2	3	4	5	Hopeful

_____ _____ _____
Signature of Applicant Relationship Date