St. Francis Home – *Resident Application*

915 N River Rd
Saginaw, MI 48609
Phone: (989)781-3150 Fax: (989)781-3791

How did you hear about us? ______________________________
Date: ____________
Name: ____________________ Gender: M - F Phone Number: ____________
Address: ________________ City __________ State: ___ Zip Code: _____
Date of Birth: __________ Place of Birth: ________________
Social Security # ________________ Medicare # ____________
Medicaid # ________________ Other Insurance: ____________
Insurance (Policy & Group #) ______________________
Primary Physician ________________ Phone: ____________
Responsible Party: ________________ Address: ________________
Phone # ____________ Relationship: __________ (please indicate if you are the DPOA)

Family Members Contact Information:

Name	Relation	Phone

Health Information

List any illness, physical or mental, that you presently have or have been treated for:__________
____
____
____

Diagnosis: ______________________________
____

Date of last hospitalization________________ Reason________________
Surgical History: ______________________________

Have you ever received services in a nursing home? Yes____ No____
If yes, where and when?______________________________

Allergies: ______________________________

Therapies: Physical___ Occupational___ Speech___

Medications: (dosage and times if available): ______________________________
____

Behaviors: Alert___ Knows: self___ place___ time___ Forgetful___ Confused___ Wanders___
Cooperative___ Aware of Admission___ Angry___ Follows directions___

Mobility: Walking: Independent ___ Assist___ Transferring: Independent ___ Assist ___ Lift___
Weakness ___ Trouble with balance ___ Cane ___ Walker ___ Wheelchair ___
Occasional falls___ How often____________________________

Skin: Clear: Y or N Rash: Y or N Open areas: Y or N If wound is present, stage: _________
*If a wound/open area is present:
Location: __________________________ Treatment/dressing: _________________________ Drainage: Y or N

Nutrition:
Ht ____'_____" Weight ______lbs Appetite: _____________ Feeds self: *Y or N* Requires help: *Y or N*
Dentures: *Y or N* Own teeth: *Y or N* Other: ____
*If a peg tube is present:
Formula: ____________ Strength: ____________ Amount: ______________ Frequency: __________

Interests:
Hobbies: ____
Likes/Dislikes: ____

Sensory:
Hearing: Normal____ Impaired____ Hearing Aids____
Visual: Normal____ Impaired____ Glasses____ Blind____
Speech: Normal____ Difficulty Communicating: ____ Nonverbal ____

Elimination:
Bladder: Toilets self ___ Frequent trips to BR ___ Wets self ___ Briefs/liners worn ___
Is a catheter present: Y or N
If yes, list special instructions: ____
Bowel: Toilet self___ Constipation___ Involuntary___ Training Program___
Other Ostomies____

Respiratory:
Oxygen ___ Sleep Apnea ___ CPAP/BIPAP Machine ___ Short of Breath ___
Sleep pattern: ____

Pain:
Location: ______________________________________ Severity: ___________________________________
What helps relieve the pain: ____

Comments/additional information:

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____

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____

CONCERNING PROSPECTIVE RESIDENT

FINANCIAL INFORMATION:

A. CASH ASSETS

Bank_______________________________________ Location______________________________

Checking Account #__________________________ Savings Account #_______________________

Balance in Account $_________________________ Balance in Account $____________________

Certificates of Deposit? YES _____ NO_____ If yes, approximate amount $_________________

B. REALESTATE ASSETS

Does applicant own home? YES_____ NO_____ Approximate value $______________________

If yes, where is property located? ____

Does applicant receive any "rental" income? YES_____ NO_____ If yes, how much per month? __________
Per year? __________

C. LIFE INSURANCE CASH VALUE

Does applicant have life insurance policies with cash value? YES_____NO_____

Approximate amount of cash value? ____

Company Name____

Agent's Name__________________________________ Phone Number______________________

D. SECURITIES

Does the applicant have stocks and bonds? YES_____ NO_____

Approximate value of all securities $____

Agent handling securities: Name____

Address____

Telephone Number__________________________________

E. OTHER INCOME

Social Security Check $___________________________ Disability Check $____________________

Pension $______________________________________ Other $___________________________

Annuity $______________________________________

AUTHORIZATION

Everything stated in this application is true and correct. I authorized St. Francis Home to check my bank references and credit history. I also understand that the facility considers this application as a continuing statement of financial condition and agree to notify the facility in writing of any substantial change in the above financial condition. All of this information will be kept strictly confidential by the facility. I agree that a photocopy shall have the full force and effect as the original of this application.

Signature of Applicant:_____________________________________ Date____________________

For St. Francis Home staff:

Date received: _______________ Staff Member: ____

Notes:

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