Hillsdale County Medical Care Facility

140 West Mechanic Hillsdale, Michigan 49242
Telephone: (517) 439-9341 Fax: (517) 439-9839 Web: www.hcmcf.com

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Application
For:(Mr./Mrs./Ms.)_____
Last First Middle

_____ _____ _____ _____
Date of Birth Birth Place Maiden Name Date of Application

I certify that all statements made by me on this application are true to the best of my knowledge and belief.

Personal Signatures Required:

Your Relationship:_____

Your Address:_____

City & State:_____

Telephone:_____

Your Signature:_____Date:_____

ADMISSION APPROVAL:

Administrator:_____Date:_____

Director of Nursing:_____Date:_____

Admission Coordinator:_____Date:_____

Date of Approval:_____

Date of Denial:_____

PAS DCH-3877,78 Date Completed: _____

MEDICAL INSURANCE

Name of Insured_____Name of Organization_____Policy Number_____Group Number

_____**Medicare**_____

_____**Medicaid**_____

_____**Other Insurance:**_____

Social Security Number:_____**Receives SSI?**___**Yes**___**No**___

PLEASE INCLUDE COPIES OF ALL INSURANCE CARDS

LEGAL DESIGNATION

Please include copies of legal designations.

Durable Power of Attorney? Yes No Name/Relationship:_____

Medical Power of Attorney? Yes No Name/Relationship:_____

Is there a Guardian? Yes No Name/Relationship:_____

RECORD OF PRESENT & PREVIOUS RESIDENCES

(Most Recent First)

Street Address Township/City State From: To: Own/Rent

_____

_____

MARRIAGE RECORD

(Most Recent First)

Applicant Married To Date Place Birth Date Widowed-Divorced-Separated

_____

CHILDREN LISTING

(Designate a #1 and #2 contact person) (List all children – living or deceased)

Last Name First Name Address Son/Dtr Home Phone Wk Phone

_____

_____

_____

_____

_____

INSTITUTIONAL CARE (AFC Home, Long-Term Care, Hospital, ER, Mental Hospital)

Individual Institution Entry Date Discharge Date Remarks

Has the applicant ever been convicted of a Felony? Yes No

EMPLOYMENT HISTORY (Applicant and spouse)

Name of Person Employer or Type of Employment

MILITARY SERVICE

Did the Applicant serve in the United States Armed Services? Yes No

If Yes, what branch and how long did they serve? Branch: Dates of Service:

Please provide discharge documents (if available) in order to maximize any military allotments for the individual.

PERSONAL FACTS

Who is your current community physician/s? 1. 2.

Do you have a religious preference? Yes No Religion:

Funeral Director/Home:

Are you currently an Organ Doner? Yes No If Yes, Explain:

Is there any history of Mental Illness or Disease? Yes No If Yes, please explain below.

Please list known surgical history:

Mental Health Factors

How would you characterize the applicant's mood?
___Negative ___Anger at others ___Anger at self ___Complains about health
___Non-health related complaints ___Insomnia ___Sadness ___Unrealistic fears
What behaviors, if any, have been exhibited?
___Wanders ___Verbally Abusive ___Physically Abusive ___Socially Inappropriate
___Resists Care Other _____
Short Term Memory ___Excellent ___Good ___Poor
Long Term Memory ___Excellent ___Good ___Poor
Mental Illness History ___Yes ___No Behavioral Medications (Examples-Risperdal/Paxil)_____

Resident Background Information

Spouse's Name _____ Children's Names ___
Rehabilitative Stay ___Yes ___No Indefinite Stay ___Yes ___No
Education (last year completed) ___Grade School ___High School ___College ___Trade School
Language: ___English ___Spanish ___German ___French ___Other_____
Occupation prior to retiring:_____Shift?_____
Veteran ___Yes ___No Do they regularly vote? ___Yes ___No

Customary Routine Prior To Admission

Stays up late at night ___Yes ___No If Yes, how late_____A.M./P.M.
Customary time of awakening _____A.M/P.M.
Where do they sleep? ___Bed ___Chair ___Other_____
Do they take sleep medication? ___Yes ___No
Do they nap regularly? ___Yes ___No If Yes, when _____
Goes out weekly ___Yes ___No If Yes, where ___Grocery ___Church ___Restaurant ___Other
Do they regularly visit beauty/barber shop? ___Yes ___No If Yes, how often?_____
Hobbies ___Yes ___No If Yes, what _____
Watch Television ___Yes ___No If Yes, favorite shows _____
Food allergies ___Yes ___No Food Preferences _____
Special food needs _____
Between meal snacks ___Yes ___No If Yes, usual snacks _____
Have you noticed an extreme weight loss or gain in the last 4 weeks to 6 months ___Yes ___No
Daily contact with relatives & friends ___Yes ___No Attends Church ___Yes ___No
Daily animal companion ___Yes ___No Prefers ____Dog ___Cat ___Other ___ Pet Name_____
Involved in group activities ___Yes ___No If Yes, what activities _____
Are they a smoker or have a history of smoking? ___Yes ___No ___Past use
Are they a consumer of alcohol? ___Yes ___No ___Past use

Communication Patterns

Hearing ___Okay ___Poor ___Right Ear ___Left Ear ___Uses Hearing Aids ___Needs Hearing Aids
Speech ___Okay ___Non-verbal ___Signs ___Written Messages
Vision ___Okay ___Wears Glasses ___Needs Glasses
Dentures ___Yes ___No ___Uppers ___Lowers ___Partial

Physical Functioning

Independently Ambulatory ___Yes ___No ___With Cane ___With Walker ___With Wheelchair
History of Falls ___Yes ___No
Feeds Self ___Yes ___No Toilets Self ___Yes ___No Bathes Self ___Yes ___No
Bowel Incontinence ___Yes ___No Bladder Incontinence ___Yes ___No
Skin Problems ___Yes ___No Foot Problems ___Yes ___No
Dresses self___Yes ___No Level of assistance: ___Independent ___Minimal ___Maximum
Bathing Preference ___Shower ___Tub ___Sponge Customary Bathing Time: ___Morning ___Evening

Social Recreational Therapy Data

Organizational involvement?_____ Does applicant read? ___Yes ___No ___Mags ___Books ___News
Does applicant enjoy playing games? ___Cards ___Checkers ___Chess ___Other _____
Does applicant enjoy music? ___Yes ___No Type of music or radio _____