



Apostolic Christian Resthaven

2750 W. Highland Ave.
Elgin, Illinois 60124
(847) 741-4543

PROSPECTIVE RESIDENT PRE-ADMISSION QUESTIONNAIRE

We would ask, at this time, that you complete this Prospective Resident Pre-admission Questionnaire. Completion of this packet is the first step of our Admission Process. The remaining steps include Interview With Resident and or Family/Representative, Formal Application for Admission, and Resident Assessment by Resthaven. During this admission process it will be determined if the best interests of the resident and Resthaven would be served by admitting the resident.

PROSPECTIVE RESIDENT INFORMATION

DATE _____

APPLICANT NAME _____ SEX _____ AGE _____

CURRENT ADDRESS _____

CURRENT PHONE # _____ SOCIAL SECURITY # _____

DATE OF BIRTH _____ PLACE OF BIRTH _____

MARITAL STATUS _____ CITIZENSHIP _____

PRIMARY DIAGNOSIS _____

SECONDARY DIAGNOSIS _____

PREVIOUS OCCUPATION _____

APPROXIMATE HEIGHT _____ APPROXIMATE WEIGHT _____

DOCTOR'S NAME _____ DOCTOR'S PHONE _____

NEXT OF KIN NAME _____ RELATION _____

CURRENT ADDRESS _____

CURRENT PHONE #(HOME) _____ (WORK) _____

PROSPECTIVE RESIDENT'S CURRENT HEALTH STATUS: (PLEASE CHECK AREAS WHICH ARE APPLICABLE.)

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> mentally alert | <input type="checkbox"/> ambulatory | <input type="checkbox"/> requires bed rails | <input type="checkbox"/> feeds self |
| <input type="checkbox"/> slightly forgetful | <input type="checkbox"/> walks with assistance | <input type="checkbox"/> continent | <input type="checkbox"/> requires help with feeding |
| <input type="checkbox"/> confused | <input type="checkbox"/> chair-ridden | <input type="checkbox"/> incontinent | |
| <input type="checkbox"/> requires special diet | <input type="checkbox"/> bed-ridden | <input type="checkbox"/> desires other company | |

SPECIAL EQUIPMENT NEEDED: (PLEASE CHECK ITEMS WHICH ARE APPLICABLE.)

- | | | |
|---|--|--------------------------------------|
| <input type="checkbox"/> colostomy supplies | <input type="checkbox"/> oxygen | <input type="checkbox"/> wheelchair |
| <input type="checkbox"/> urostomy supplies | <input type="checkbox"/> elevating leg rests | <input type="checkbox"/> geri-chair |
| <input type="checkbox"/> nasal gastric tube | <input type="checkbox"/> parental feedings | <input type="checkbox"/> hooyer lift |

PLEASE CHECK SOURCES OF PAYMENT:

- | | |
|---|---|
| <input type="checkbox"/> Personal money and assets of resident | <input type="checkbox"/> Social Security payments |
| <input type="checkbox"/> Longterm Care Insurance | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Personal money and assets of responsible party | <input type="checkbox"/> Railroad Retirement payments |

DATE OF ADMISSION DESIRED: _____ **TYPE OF ROOM DESIRED:** SEMI-PRIVATE PRIVATE

PLEASE CHECK CURRENT LIVING ARRANGEMENT STATUS:

- Home alone (or with spouse)
- Home with caregiver
- Living with family/friend
- In retirement/assisted living facility
- Placed in nursing home
- Other: _____

PLEASE CHECK CURRENT ADMISSION STATUS:

- Ready for placement at ACR
- Call when first bed is available
- Family will call ACR when closer to needing placement
- Other: _____

Please return the completed "Prospective Resident Pre-admission Questionnaire" to Apostolic Christian Resthaven, 2750 W. Highland Ave., Elgin, IL 60124. If you have any questions or additional comments, please list them on a separate sheet.

<p>APPLICATION FEE OF \$200 IS NON-REFUNDABLE AND IS NOT APPLICABLE TO MEDICAID APPLICANTS I UNDERSTAND THAT THE \$200 APPLICATION FEE IS NON-REFUNDABLE.</p>	
<hr style="border: none; border-top: 1px solid black;"/>	<hr style="border: none; border-top: 1px solid black;"/>
Signature of Applicant or Next of Kin	Date



Apostolic Christian Resthaven

Please fill out the following information. While this information will not solely determine acceptance into Apostolic Christian Resthaven, it will be helpful in determining the ability of the resident for paying the cost of care as well as assist our facility in annual budget computations.

Is resident handling all financial and personal matters? Yes No

Is party authorized to handle all financial & personal matters? Yes No

If so, attach a copy of basis for authorization (e.g. power of attorney, trust agreement).

I authorize Apostolic Christian Resthaven personnel to verify the information contained herein.

Signature _____ Date _____

BANK ACCOUNTS

CHECKING: Joint Account Yes No

Bank _____ Account Totals _____

SAVINGS: Joint Account Yes No

Bank _____ Account Totals _____

CERTIFICATE(S) OF DEPOSIT: Joint Account Yes No

Bank _____ Account Totals _____

Total Net Worth of Bank Accounts \$ _____

STOCKS AND BONDS

Total Net Worth of All Stocks and Bonds \$ _____

REAL ESTATE

Name(s) Title(s) are in: _____

Total Net Worth of Real Estate \$ _____

INSURANCE

Total Net Worth of Insurance \$ _____

OTHER ASSETS

List any other assets of resident, not previously listed above _____

Total Net Worth of Other Assets \$ _____

Total Net Worth of Resident \$ _____

Total Monthly Income of Resident (Social Security, Pension, etc.) \$ _____



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RESIDENT AUTHORIZATION ALLOWING APOSTOLIC CHRISTIAN RESTHAVEN TO REVIEW MEDICAL RECORDS

TO: _____

I, _____, hereby authorize your facility/office to allow Apostolic Christian Resthaven representative(s) to review all medical records of _____, a resident/patient of your facility/office. I am the resident/resident representative/guardian whose name appears below.

Resident Signature

Resident Name (print)

Representative or Guardian Signature

Representative or Guardian Name (print)

Facility Representative Signature