Application for ___ Residence ___ Respite

beginning _____and ending_____
date date

Applicant's Name _____ Date _____

Age: _____ Birth Date _____ Birth Place _____

Applicant's Address (before admission) _____

Phone Number:_____ Marital Status: __ Single __ Married __ Divorced __ Widowed

Family Member/Caregiver's Name _____ Relationship_____

Family Member/
Caregiver's Address _____
street city state zip

Is applicant living with caregiver?___ yes; if no, indicate where _____

Insurance Information:

Medicare (Part A #) _____ Medicare (Part B #) _____

Supplemental Insurance Carrier _____ ID # _____

Part D Insurance Provider _____ ID # _____
(drug coverage)
Long Term Care Provider _____ ID # _____

Medical Information:

Physician's Name _____ Phone # _____
Physician's Address _____

Dentist's Name _____ Phone # _____

Pharmacy Name _____ Phone # _____

Podiatrist Name _____ Phone # _____

Optometrist/Ophthalmologist Name _____ Phone # _____

Medical Information (continued)

Applicant's Name _____ Male ___ Female ___

Height _____ Weight _____ Dietary Restrictions: _____

Activity Restrictions (that prevent participation in exercise/activities program):

_____

History of alcohol addiction? ___ yes ___ no; drug addiction? ___ yes ___ no

History of:

___ chronic lung disease?
___ cardiovascular disease?
___ gastrointestinal disorder?
___ genitourinary dysfunction or disease?
___ anemia?
___ neurological disease?
___ arthritis?
___ emotional instability?
___ mental health disorder?
___ skin disease?
___ serious impairment of sight?
___ serious impairment of hearing?
___ malnutrition?
___ allergies?

Please Attach a Current List of Medicines: Include name, dose and frequency and "as needed" medications.

Does the applicant have: A Living Will? ___ yes ___ no
A Durable Power of Attorney for Health Care? ___ yes ___ no
An I-Post? ___ yes ___ no

If so, the caregiver should provide Hallmar with copies (unless it is already in the Mercy Medical Center computer system).

Is the applicant a registered organ/tissue donor? If yes, please explain _____

_____

How did you hear about Hallmar?

___Family or Friend ___ Mercy Medical Center ___ Family Caregivers Center of Mercy

___ Website ___ Physician (please specify) _____

___Other (please specify) _____

Why are you interested in Hallmar? _____

_____

Funeral Home of Choice: _____ Phone # _____

Current community services for applicant:

___ non-medical in-home care
___ day center,
____ hospice,
____ palliative care
____ other (please list or explain)

Emergency Contacts

Would the applicant want to be given his/her own bill? ___Yes ___ No

If, no whom should the bill be mailed?

Name _____ Relationship _____

Address_____

Home #_____ Cell # _____ Work # _____

Please list names and phone numbers of immediate family members and others to be contacted in case of an emergency.

1. Name _____ Relationship _____

Home #_____ Cell # _____ Work # _____

2. Name _____ Relationship _____

Home #_____ Cell # _____ Work # _____

3. Name _____ Relationship _____

Home #_____ Cell # _____ Work # _____

Please list Emails for those who would like to receive Hallmar Newsletter/Announcements:

Name: _____ Email: _____

Name: _____Email:_____

Name: _____Email: _____

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Financial Information for Residence

If applying for residence, the attached form must be completed.

Financial Information for Respite

If you as the caregiver are self-paying for the respite stay, Hallmar asks that you provide cash and/or a check for the amount of the cost of the respite stay when the care receiver moves in to begin the stay.

If you are receiving assistance from the Family Caregivers Center of Mercy to pay for respite, please give Hallmar the form you received showing the number of nights for which you are qualified. Hallmar will bill the Family Caregivers Center.

If you, as the caregiver, will pay for part of respite and the Caregivers Center will pay part, then you will need to pay your share of the cost when the care receiver moves in as well as present the form from the Caregivers Center.

FINANCIAL INFORMATION

ASSETS AVAILABLE FOR HALLMAR*

Monthly Income	**Amounts**
Long-Term Care Insurance	_____
Social Security	_____
Other	_____

Assets	**Amounts**
Bank Account(s)	_____
Real Estate	_____
Investment(s)	_____
Other	_____

According to my best knowledge and belief, the foregoing information is complete, accurate and true in all aspects. I understand the accuracy of the above financial Report is made as one of the conditions of my acceptance at Hallmar, and that the total resources listed on my application are available for my personal use at Hallmar.

*A letter of financial status from a financial institution will be acceptable. This letter must confirm adequate finances.

Signature of Applicant or Guarantor_____ Date_____