5101 Harrisburg Rd. Jonesboro, AR 72404
craigheadcnc.org

Application for Admission

Name of Applicant:_____ Sex: ___M ___F Date:_____

Address:_____County:_____

Date of Birth:_____ Place of Birth:_____ Previous Occupation:_____

Marital Status:_____ Is applicant a Veteran and/or receives VA benefits: ____Yes ____No

Social Security # ____- ____- _____ Medicare # _____ Medicaid # _____

Other Medical/Prescription Insurance: _____

HEALTH INFORMATION

Physician:_____ Date of last hospitalization: _____ Hospital:_____

Pharmacy:_____ Ambulance: ___Medic One ___Emerson

Has applicant fallen in the last (6) months? ____ Yes ____ No If yes, when: _____

Does applicant need assistance with:

Dressing: ____Yes ____No Bathing: ____ Yes ____ No Eating: ____ Yes ____ No

Does the applicant need any of the following ____Cane ____ Walker ____Wheelchair ____Assist with standing/walking

Does the applicant have a history of Dementia or Alzheimer's disease? _____ Yes _____ No

Is the applicant oriented to ____person ____place ____time or ____Situation

List any nursing home stays in the last 5 years: _____

EMERGENCY CONTACTS

Name: _____ Relationship:_____ Phone #_____Home or cell

Address:_____

Second Contact

Name: _____ Relationship:_____ Phone #_____Home or cell

Address:_____

ADDITIONAL INFORMATION

Religion:_____ Funeral Home: _____ Phone #:_____

Has applicant executed any Advanced Directives (i.e. Power of Attorney- healthcare/finances) _____Yes _____ No

If yes, please describe and list who the designated agent is:_____

Comments: _____

_____

_____

FINANCIAL

Does the applicant plan to apply for Long Term Care Medicaid? _____Yes _____ No

Has applicant ever applied for Medicaid in the past? ____Yes ____No

If yes, when: _____ Was application _____ accepted _____ rejected

Has the applicant transferred any assets in the last 5 years? (this includes real estate, funds, personal property, etc)

____Yes ____ No If yes, what assets were transferred and the value of items: _____

_____

Does applicant own their own home? _____Yes _____ No

If yes, address of the home: _____

Does the applicant have any life insurance policies? ____Yes ____ No

If yes, what is the cash surrender value of all policies? _____

MONTHLY INCOME

1. SOCIAL SECURITY $_____
2. PENSION $_____
3. ANNUITIES/TRUST $_____
4. OTHER $_____

TOTAL MONTHLY $_____ x 12 MONTHS = $_____

ASSETS:

1. STOCKS & BONDS $_____
2. CHECKING/SAVINGS $_____
3. REAL ESTATE $_____
4. C.D.'s $_____
5. OTHER $_____

There are funds to pay for care (less than 6 months) (____ Months) (1 Year) (2 Years) (More than 2 years)

Person making application for admission:

Signature:_____ Phone #_____ Date:_____

Craighead Nursing Center does not discriminate against anyone based on race, color, religion, sex, or national origin, age, sex, or handicap. Craighead Nursing Center is prohibited from admitting persons with physical or mental health problems that proper care cannot be provided.