Asheir Manor
Assisted Living
Providing Quality Care from the Heart
www.asheirmanor.com 301-250-6660 (main) 301-798-5125 (fax)

APPLICATION FOR ADMISSION to ASHEIR Manor, LLC

Applicant Name: _____ Date of Application: _____

DOB: _____ Age: _____ Social Security# _____

Health Insurance Company_____

Policy # _____ Medicare # _____

Have you ever visited Asheir Manor? ☐ YES ☐ NO

How did you hear about Asheir Manor?

_____

_____

This application must be filled out completely in order to process your admission into facility. If there is no bed availability at the time in which you submit this application, or if you are not ready to admit your loved one, you may elect to be placed on a waiting list. All information will be kept confidential.
14 day fee is required *with* application to hold bed up to 14 days.
One month fee is required *with* application to hold bed up to 30 days.
(This fee is refunded when resident moves in.)

I. GENERAL INFORMATION:

Applicant's Date of Birth ___/___/___ AGE_____ Sex _____
Mo Day Year Male/Female

_____
Applicants Present Whereabouts

_____
Most Recent Address City State

_____ _____
Marital Status Religion (optional)

II. HEALTH INFORMATION:

Height___ Ft. ___In. Wt_____lbs.

Current Diagnosis: _____ Current Diet Restrictions: _____

_____ _____ ( ) _____
Current Physician Address Phone

May we contact Physician? ☐ YES ☐ NO

Last Flu Vaccine ___/___ Last Pneumonia Vaccine ___/___

Does applicant currently smoke? ☐ YES ☐ NO Is there a history of smoking? ☐ YES ☐ NO

Any previous stays in other Facilities – ☐ Nursing Home ☐ Assisted Living ☐ Group Home ☐ Rehab ☐ Hospital

Date of Stay	Name of Facility	Reason Services Received
___/___/___ Mo Day Year	_____	_____
___/___/___ Mo Day Year	_____	_____

Reason for wanting to leave current facility _____

_____

Has applicant received any of the following services? Check all those that apply.

☐ An Attorney ☐ Community Organization ☐ Home Health Agencies
☐ Care Management Services ☐ Social Service Agency ☐ Adult Protective Services (APS)
☐ Other Please Describe: _____

APPLICANTS CURRENT LIVING ARRANGEMENTS AND ABILITY TO CARE FOR SELF

A.	☐ In own home/apartment	☐ Independent	☐ With Assistance
B.	☐ Lives with Family	☐ Independent	☐ With Assistance
C.	☐ In an Assisted Living/Group Home	☐ Independent	☐ With Assistance
D.	☐ In a Nursing Home		

Please check all that apply:

- ☐ Mentally Alert
- ☐ Confused some/all the time
- ☐ Ambulatory
- ☐ Walks with Assistance
- ☐ Can climb stairs with assistance
- ☐ History of Psychiatric treatment
- ☐ Behavior issues
- ☐ Uses wheelchair
- ☐ Wanders
- ☐ Cannot climb stairs

III. FAMILY / RESPONSIBLE PARTY INFORMATION

Billing Contact:

List person holding **Financial Power of Attorney** or person who will be receiving the monthly bill.

_____ _____ Home Phone: _____
Name Relationship

_____ Work Phone: _____
Address

_____ Cell Phone: _____
City State zip

E-mail: _____

Do you wish to be listed as the contact person in case of emergency? ☐ YES ☐ NO

HEALTHCARE CONTACT:

List person holding the Healthcare Power of Attorney or person who will be contacted for medical needs.
Is the health care contact the same as the billing contact: ☐ YES ☐ NO (if NO please fill out below info.)

_____ _____ Home Phone: _____
Name Relationship

_____ Work Phone: _____
Address

_____ Cell Phone: _____

E-mail: _____

Please list a second emergency contact:

_____ _____ Home Phone: _____
Name Relationship

_____ Work Phone: _____
Address

_____ Cell Phone: _____
City State zip

E-mail: _____

IV. FINACIAL PROFILE

To process your application, the following information is required. The information supplied is confidential and allows us to establish that resident has adequate resources for purpose of long-term planning. The financial data should be that of the Resident/and or the Guarantor. All income and amounts listed, whether listed under Guarantor or Resident, must be either owned by the resident or be available to the resident to pay for residents stay at facility. *Please provide evidence of assets/income by providing copies of statements.* Note that it is not mandated that a resident have a Guarantor, only that a source of payment be identified.
Please complete the following information:

Assets	Resident	Guarantor (if any)
Cash	$_____	$_____
Checking	$_____	$_____
Savings	$_____	$_____
Money- Market	$_____	$_____
Certificates of deposit	$_____	$_____
Securities (Stock/Bonds	$_____	$_____
Trust	$_____	$_____
Annuities (if not yet paying monthly)	$_____	$_____
IRA	$_____	$_____
Other	$_____	$_____
MONTHLY INCOME:		
Salary	$_____	$_____
Social Security	$_____	$_____
Pension/Annuities (if not above)	$_____	$_____
IRA (if not above)	$_____	$_____
Interest/Dividend Income	$_____	$_____
Rental Income	$_____	$_____
Trust Long-Term care Insurance	$_____	$_____
Estimated Survivor income	$_____	$_____

REAL ESTATE: (description/location)

(1) Property: _____ _____ _____
Name on Deed/Title: _____
(2) Property: _____ _____ _____
Name on Deed/Title: _____

Other Assets

	Original Face	Current Cash Value of
Life Insurance	_____	_____
Vested Pension Benefits	_____	_____
Business Interests	_____	_____
Automobiles	_____	_____
Other	_____	_____

TOTAL ASSETS

I hereby attest that the above financial information is accurate and assets are intended for the Resident to pay for services received at ASHEIR Manor, LLC. It is understood that ASHEIR Manor, LLC relies on the accuracy and completeness of the information furnished in order to make Admission Decision.

_____ _____
Family/Responsible Party Signature Date

Asheir Manor

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The Following Items Must Be Completed Before Resident Can Move In To The Facility:

- ☐ **Admission Application**
- ☐ **Admission Fee**
- ☐ **Burial Arrangements Approval**
- ☐ **Chest X-ray or PPD results showing that resident is free from TB**
- ☐ **Completed MOLST**
- ☐ **Consent to Photograph**
- ☐ **History and Physical From Physician**
- ☐ **List of Current Medications From Physician**
- ☐ **Insurance Card (copy)**
- ☐ **Physician Orders**
- ☐ **POA Papers (copy)**
- ☐ **Resident Agreement**

RESPITE RESIDENTS ONLY

- ☐ **Admission Application**
- ☐ **Burial Arrangements Approval**
- ☐ **Chest X-Ray Or PPD Results Showing That Resident Is Free From TB**
- ☐ **Completed MOLST**
- ☐ **Emergency Information**
- ☐ **H&P From Physician**
- ☐ **Insurance Card (Copy)**
- ☐ **List Of Current Medications From Physician**
- ☐ **Medications For Administration For Length Of Stay** - *(Respite Resident's Only)*
- ☐ **Payment In Full For Length Of Stay -** *(Respite Resident's Only)*
- ☐ **Physician Information (Name/Address/Telephone)**
- ☐ **Physician Orders**
- ☐ **POA Papers (Copy)**
- ☐ **Resident Agreement**