

The Good Samaritan Home, Inc.

601 North Boeke Road
Evansville, Indiana 47711
(812) 476-4912
Fax (812) 474-4442

Long Term Care Application

Name: _____ Nickname: _____

Present Address: _____

Telephone # _____ Social Security # _____ Medicare # _____

Age: ____ Date of Birth ____/____/____ Place of Birth: _____ Marital Status S W D M

Church Affiliation/Preference _____ Pastor/Minister _____

Address: _____ Phone # _____

Name and Addresses of Contacts:

Name	Relationship	Address (City,State,Zip)/Phone # (Home and Work)
1. _____		
2. _____		
3. _____		

My physician is: _____ Address/Phone: _____

Hospital Preference: _____

Funeral Home Preference: _____ Address Phone # _____

It is required that each resident of the Good Samaritan Home have at least one of the following: Dentist, Eye Doctor, and Podiatrist. If you have no preference the Good Samaritan Home has consultants available to make in-house visits. If you wish to use our consultants, please write "House" in the spaces provided below. If you wish to chose your own, please write, the name, address, and phone number of your preference below.

Dentist: _____ Address/Phone: _____

Optical Preference: _____ Address/Phone: _____

Podiatrist: _____ Address/Phone: _____

Name of Health Insurance/Medicare Supplement: _____ Policy # _____

Do you have a Long-Term Care Policy? YES No. If yes, please list insurance carrier, policy number, and identification number(s): _____

Do you have Medicare D? YES NO. If yes, please list policy information: _____

* We are a Medicare and Medicaid approved facility.

Is someone other than yourself responsible for managing your financial matter: ___ Yes ___ No

If yes, please specify: Name _____ Relationship _____

Address: _____ Phone # _____

Will you need our assistance in applying for Medicaid upon admission? ___ Yes ___ No

Is there a Power of Attorney (P.O.A.) or Guardianship in effect? ___ Yes ___ No If so, please state who holds this position: _____ Please list all other directives that are in place: ie; Living Will, Healthcare Representative: _____

Pertinent Medical and Current Information: (if the potential resident is currently in another healthcare facility or the hospital this section is not required to be completed)

Height: _____ Weight: _____ Primary Diagnosis: _____

Physical Condition:

___ Good

___ Fair

___ Poor

Mental Condition:

___ Clear

___ Confused

___ Very Confused

Ambulation:

___ Self

___ With Assist

___ Non-Ambulatory

Most recent hospitalization and reason for: _____

Permanent Disabilities: _____

Habits: ___ Coffee ___ Tea ___ Smoking ___ Alcohol ___ Other: _____

Dietary History: _____ Drug Sensitivities/Allergies _____

Current Medications (both prescribed and over the counter): _____

Bowel: ___ Controlled ___ Uncontrolled Bladder: ___ Controlled ___ Uncontrolled

List any special problems: _____

Functional limitations, or special needs, such as glasses, dentures, prosthesis, etc.: _____

Signed: _____ Date: _____

For Office Use Only:

Date Application Received: ___/___/___ Admission Date: ___/___/___ Medical records #: ___/___/___

