

CHAMPAIGN COUNTY NURSING HOME APPLICATION

DATE _____ (DATE RECEIVED BY CCNH _____)

APPLICANT'S NAME _____

ADDRESS _____

PHONE NUMBER _____

MALE _____ FEMALE _____ DATE OF BIRTH _____

NAME OF PRIMARY PHYSICIANS _____

HOSPITAL _____ CLINIC # _____

MEDICARE # _____ A / B / A&B

SOCIAL SECURITY # _____ MEDICAID # _____

INSURANCE NAME AND NUMBER _____

DIAGNOSIS (MAIN HEALTH PROBLEM) _____

LIST OF MEDICATIONS _____

PAYMENT SOURCE (CHECK ALL APPROPRIATE)

____ PRIVATE FUNDS

____ MEDICARE

____ MEDICAID / PUBLIC AID - CASE NUMBER _____

____ LONG TERM CARE INSURANCE - HOW MANY MONTHS COULD BE COVERED BY POLICY? _____

AVERAGE MONTHLY RATE IS \$4500, HOW LONG BEFORE PUBLIC AID WILL BE NEEDED? _____

LOCAL CONTACTS:

NAME _____ RELATIONSHIP _____

ADDRESS AND ZIP _____

1ST PHONE NUMBER _____ 2ND PHONE NUMBER _____

NAME _____ RELATIONSHIP _____

ADDRESS AND ZIP _____

1ST PHONE NUMBER _____ 2ND PHONE NUMBER _____

DOES THE APPLICANT HAVE A LEGAL GUARDIAN? YES_____ NO_____

DOES THE APPLICANT HAVE A HEALTH POWER OF ATTORNEY? YES_____ NO_____

DOES THE APPLICANT HAVE A LIVING WILL? YES_____ NO_____

IF ANY OF THE ABOVE IS YES, LIST THE PERSON DESIGNATED_____

PLEASE INDICATE THE NEED FOR PLACEMENT (CHECK ONE)

IMMEDIATE_____ WILL CALL CCNH WHEN READY_____

ADDITIONAL INFORMATION_____

APPLICANT IS NOW: LIVING ALONE_____ LIVING WITH RELITIVES_____

LIVING AT A NURSING HOME_____

LIVING AT AN ASSISTED LIVING_____

OTHER RESOURCES YOU HAVE USED OR EXPLORED:

HOME HEALTH_____ ADULT DAY CARE_____ TELECARE_____ OTHER_____

HOMEMAKERS_____ MEALS-ON-WHEELS / PEACE MEALS_____

PLEASE MARK ITEMS THAT DESCRIBE APPLICANT:

ACTIVITY:		KIDNEY / BOWELS:		MENTAL STATUS:	
Walks independently	_____	Complete control	_____	Alert	_____
Walks with walker	_____	May have accidents	_____	Forgetful	_____
Walks with cane	_____	Usually incontinent	_____	Confused	_____
Needs help to walk	_____	Indwelling catheter	_____	Withdrawn	_____
Uses wheelchair	_____	Ostomy	_____	Combative	_____
Needs help to get in/out of bed/chair	_____			Needs restraints	_____
Dresses self	_____	EATING:		Wanders outdoors	_____
Needs help dressing	_____	Feeds self	_____	Wanders indoors only	_____
Needs help transferring	_____	Needs help	_____	Elopement risk	_____
		Needs feeding	_____	Suicide attempts / thoughts	_____
		Special tube feeding	_____	Psychiatric hospitalization	_____
				Diagnosis of a major mental illness	_____
