

VILLA SCALABRINI RETIREMENT CENTER AND SPECIAL CARE UNIT

IDENTIFICATION/EMERGENCY INFORMATION – PRE-ADMISSION

1) Name of Applicant _____ Phone _____
Address _____ City _____ State _____ Zip Code _____

2) For which section of the Villa is applicant applying? (Please check one) **Retirement Center** **Special Care Unit**

3) Is applicant currently living in a retirement center or nursing home? (Please check one) YES NO

If YES, name of home: _____
Address _____ City _____ State _____ Zip Code _____

May we call for information? **YES** **NO**

If YES, name of person to contact: _____ Phone: _____

4) Age: _____ Birthday: _____ Birthplace: _____
Sex: _____ Religion: _____ Nationality: _____
Marital Status: _____ If widowed, date of spouse's death: _____

5) Is there a person or agency who has legal authority or who has been designated as responsible party for the applicant?
YES **NO** If YES, check the category which applies:

Conservator: _____ Guardian: _____ Power of Attorney: _____
Designated responsible party: _____ Other: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Relationship to applicant: _____

6) Person (family or friends) to be notified for more information prior to admission and for concerns or emergencies after admission: (Please list three person, however only one person will be contacted; list in priority order)

a) Name: _____ Relationship to applicant: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

b) Name: _____ Relationship to applicant: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

c) Name: _____ Relationship to Applicant: _____
Address: _____ City: _____ State: _____ Zip Code: _____
Home Phone: _____ Work Phone: _____ Cell Phone: _____

7) Attending Physician: (after admission)

Does the applicant plan to use the Villa's attending physician who is on the staff at the **Pacifica Hospital of the Valley**?
YES **NO** If NO, please specify attending physician to be used after admission.

Physician Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

Hospital Preferences. Name: _____ City: _____

8) Podiatrist (Foot Doctor): (after admission)

Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

9) Dentist: (after Admission)

Name: _____ Phone: _____
Address: _____ City: _____ State: _____ Zip Code: _____

10) Financial Information: (please copy and attached all current cards)

Social Security Number _____ Medicare Number _____ EffectivDate _____

Is the applicant eligible for the Supplemental Security Income? (SSI)? **YES** **NO**

If YES, please attached a copy of the eligibility letter and the most current check.

Is applicant eligible for Medi-Cal? **YES** **NO** if YES, Medi-Cal Number _____

Supplemental Insurance _____ Effective Date _____

Who should received the Villa Monthly Statement? _____, If other please state below:

Name: _____ Relationship to applicant: _____

Address: _____ City _____ State _____ Zip Code _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SPECIAL CARE APPLICANTS: If the monthly rate (double occupancy) is approximately \$ _____, how long can the applicant pay privately? _____ months

RETIREMENT CENTER APPLICANTS: Occupancy preferences: **Single** **Double**

Rate Preferences \$ _____

11) Arrangement in Event of Death:

Mortuary Name: _____ Phone Number: _____

Address: _____ City _____ State _____ Zip Code _____

12) I hereby certify that the information on this form is true and complete

Signature of Applicant or Applicants Representative _____ Date _____