

Mental Status Information:

	Yes	No
1. Is the applicant alert?	<input type="checkbox"/>	<input type="checkbox"/>
2. Does the applicant recognize the family?	<input type="checkbox"/>	<input type="checkbox"/>
3. Does the applicant speak a language other than English?	<input type="checkbox"/> _____	<input type="checkbox"/>
4. Is the applicant confused?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, do you feel the confusion is: (please circle)		
a. Mild		
b. Severe		
5. Does the applicant experience hallucinations?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, has the applicant been treated for hallucinations?	<input type="checkbox"/>	<input type="checkbox"/>
6. Does the applicant exhibit any aggressive behavior?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please provide additional information _____		

Financial Information:

Financial arrangements upon admission to Broadlawn:

- Private Funds Medicaid Private Insurance Other

If other, please specify _____

Social Security Number: _____ Medicare Number: _____

If applying for ***Adult Day Health Services***, please indicate amount of Medicaid overage, _____

Medicaid Number: _____ Medicaid County: _____

Medicaid Caseworker name and telephone number: _____

Amount of monthly income:

Social Security: _____ Veterans Benefits: _____ Pension: _____

Disability: _____ Other Income (annuities, dividends, etc): _____

Do you receive food stamps? Yes No

If yes, how much? _____

Health Insurance Information:

Name of Insurance Company: _____

Address: _____

Telephone No. _____ Policy/Identification No.: _____

Name of policy holder: _____

7. Do you have home care (Personal Care Aide)? Yes No

If yes, Specify the time each day:

Days: Mon. _____
Tues. _____
Wed. _____
Thurs. _____
Fri. _____
Sat. _____
Sun. _____

Department of Social Services, Registered Nurse:

Name: _____ Phone #: _____

Home Care Agency:

Name: _____

Contact Person: _____ Phone #: _____

8. Are you a participant of a LTHHCP
(Long Term Home Health Care Program)? Yes No

If Yes, Name: _____

Contact Person: _____

Are you receiving any assistance from any Social or Health Agencies at this time?

Yes No

Name of Agency: _____

Contact Person: _____

I have been referred to Broadlawn Manor Day Care Program by: _____

**BROADLAWN MANOR DOES NOT DISCRIMINATE IN THE ADMISSION
OR RETENTION OR CARE OF ITS RESIDENTS BECAUSE OF RACE,
CREED, COLOR, NATIONAL ORIGIN, SEX, DISABILITY, AGE, SOURCE
OF PAYMENT, MARITAL STATUS OR SEXUAL PREFERENCE.**

I hereby declare that the information provided in this application is accurate to the best of my knowledge.

Signature: _____
Applicant

Family Member/Caseworker

Date: _____

Date Received: _____ By: _____