EASTERN STAR Masonic Home

Admission Application

Full Name: _____
First Middle Last

Address _____
Street Number City State Zip

Social Security Number _____ - _____ - _____ Phone _____ - _____ - _____

Member of O.E.S _____ Chapter # _____ Location _____

How long have you lived at the above address? _____

Date of Birth: Month _____ Day _____ Year _____

Place of Birth: Town _____ State _____

Marital Status: M_____ S _____ Sep _____ D _____ W _____

Name of Spouse _____ Date of Death (if deceased) _____ /____ /_____

Your Children:

Name:	Address:	Home Phone:	Cellphone:

Close Relatives:

Name:	Address:	Home Phone:	Cellphone:

In Case of Emergency, Contact:

Full Name: _____
First Middle Last

Are you a veteran? Y _____ N _____

Are you a veteran's spouse? Y _____ N_____

If a veteran, do you currently receive VA meds? Y _____ N _____

Do you plan on using VA meds when you enter Eastern Star? Y _____ N_____

Are you eligible for or receive other VA benefits? Y _____ N _____

If so, please list: _____

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Educational background _____

Your profession _____

Military experience _____

Hobbies _____

Organizations you belong/ed to _____

Church/Religious affiliation _____

Personal Health History

(Completed by Applicant)

Do you have any disabilities? (describe) _____

_____

Give approximate dates and nature of major illnesses or surgeries you have had: _____

_____

_____

Do you have any condition(s) which may require bed care, special treatment, or diet? _____

_____

Do you have a history of mental illness? _____

Do you walk at all times without assistance? _____

Do you dress yourself without assistance? _____

Can you care for all your daily needs? _____

Do you personally care for your present living quarters? _____

Health Insurance Y _____ N _____ Accident Insurance Y _____ N_____ Name of Company _____

Do you have Long Term Care Insurance? Y _____ N _____ Name of Company _____

Medicare # _____ Supplemental Insurance name and # _____

References: _____

Pastors Name: _____ Address: _____

Friends Name: _____ Address: _____

Estimated Date of Entry: _____/____/_____

As soon as possible _____ Within One Year _____ Will Notify the Facility _____

Comments: _____

_____

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Medical History and Physical Exam

The following person applied for admission to Eastern Star Masonic Home and has authorized you to provide is with the information requested. We would appreciate your completing this form and returning it to Eastern Star at your earliest convenience.

Name: _____ Birthdate: ____/____/_____

Address: _____ City: _____ State: _____ Zip: _____

I have known _____ for _____ years and submit the following information as to his/her past and present health.

B/P: _____ Weight: _____ Height: _____

Any Known Allergies: _____

Reactions: _____

Urinalysis: Sp/G: _____ Albumin: _____ Sugar: _____ RBC: _____ WBC: _____

Blood Analysis: HgB: _____ Hct: _____ RBC: _____ WBC: _____

Any abnormal laboratory reports concerning blood or urine analysis:

_____

Has the applicant had any of the following diseases or conditions? _____

Indicate type/date:

Gallbladder _____	Indigestion _____	Nocturia _____
Tuberculosis _____	Kidney _____	Bladder Incontinence _____
Heart _____	Prostate _____	Bowel Incontinence _____
Liver _____	Malignancies _____	Hernia _____
Chronic Diarrhea _____	Diabetes _____	Stroke _____
Seizures _____	Vascular _____	Disorientation _____
Neuritis _____	Chronic Cough _____	Depression _____
Skin Lesions: _____	Stomach _____	Anxiety _____
Asthma _____	Intestinal _____	Hypertension _____
Arthritis _____	**Psychiatric** _____	
Hemorrhages: Nose _____	GI _____	Other: _____

Any pertinent information regarding the above diseases or disorders? _____

_____

Any other diseases or abnormalities? _____

_____

Any Surgeries? When? _____

_____

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Any significant illnesses in the past 5 years? _____

_____

How do you rate the cognitive ability of the applicant? _____

_____

A. Recent Memory (Short Term) _____

B. Past Memory (Long Term) _____

Eyesight _____ Hearing _____

Prothesis in use or needed (glasses, dentures, hearing aide(s), walker, cane, etc.) _____

_____

Diet _____

Does the applicant need help with activities of daily living (dressing, bathing, eating, ambulation)? If so, please explain _____

Medications (including dosage)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Chest x-ray or Mantoux required _____

How do you rate the current health condition of the applicant? _____

Please check the level of care you believe the applicant needs.

_____ Licenses Residential Care – For those who need minimal assistance with some activities of daily living. These people may need help with bathing and medications, but do not require nursing care.

_____ Licensed Intermediate Care – For those who need care under the direction of a qualifies nurse. These people have medical problems that require daily or more frequent monitoring.

Authorization: My attending physician is herby authorized to provide Eastern Star Masonic Home any information you may have regarding my condition when under observation or treatment by you including the history obtained, physical and laboratory findings and your conclusions. I understand that the proceeding information will be regarding as confidential and that the cost of the examination is paid by me.

Applicant Signature: _____ Date: ____/____/_____

Physicians Signature: _____ Date: ____/____/_____

715 W. 3rd St., Boone, IA 50036 • Phone: 515-432-5274 • Fax: 515-432-5276 • www. iowaoeshome.com

EASTERN STAR Masonic Home

Financial Statement

Assets

Cash	$_____
Accounts Receivable	$_____
Bank Accounts	$_____
Stocks/Bonds	$_____
Home	$_____
Other Real Estate	$_____
Cash Value of Life Insurance	$_____
Other Assets	$_____
TOTAL ASSETS	$_____

Liabilities

Notes Payable	$_____
Mortgage on Home	$_____
Other Liabilities	$_____
TOTAL LIABILITIES	$_____

Monthly Income

Real Estate Rentals	$_____
Investments	$_____
Social Security	$_____
Annuities	$_____
Pensions	$_____
Trust Fund	$_____
Other Sources	$_____
TOTAL MONTHLY INCOME	$_____

The applicant further agrees and promises to maintain at a minimum in the future his/her present approximate financial position regarding the ability to pay for the facilities services. If the applicant significantly reduces his/her financial position so that he/she may no longer have the ability to pay, then the applicant understands and agrees that this change will justify the facility in then refusing or turning away the applicant form admission to the facility.

Applicant Signature:_____ Date: ____/____/_____

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