

For office use only

Adm. # _____

Doctor _____

A/D _____

Room # _____

Medicare Stay _____

PT/OT _____

SAUER HEALTH CARE

1635 West Service Drive

Winona, MN 55987

(507) 454-5540

FAX (507) 454-1647

Admission Information

Date: _____

Name of Applicant

Last

First

Middle

Address _____ City _____ State _____ Zip _____

Telephone No. _____ Current Location (i.e. hospital, etc) _____ Date of Birth _____

Social Security No. _____ Medicare No. _____

(Please supply copies of both cards)

U.S. Citizen: Yes/ No Prior Occupation: _____ Years of Education: _____

Marital Status: Single _____ Married _____ Widow _____ Widower _____ Sep _____ Divorced _____

Name of Spouse _____ Living _____ Deceased _____ Veteran OR widow/widower of Veteran? _____

List Contacts Below: *(Please Note: This is how names will be listed in the Resident's Medical Record for all notifications)*

Cell/Work phone: _____

1. Name _____ Home Phone: _____

Address _____ Relationship: _____

Cell/Work/ phone: _____

2. Name _____ Home phone: _____

Address _____ Relationship: _____

RELIGIOUS AFFILIATION: _____ Local Church _____

PREFERRED FUNERAL HOME

Address _____ Phone _____

(If left blank, Martin-Myhre F.H. of Winona will be used as holding facility)

FINANCIAL INFORMATION:

Are you currently receiving: VA _____ SS _____ SSI _____ Medical Assistance _____

Do you have a legally appointed Guardian or Conservator? Yes No Name _____

Do you have a Power of Attorney (Financial)? Yes No Name _____

Address _____ Phone _____

Do you have a Power of Attorney for Health Care? Yes No Name _____

Address _____ Phone _____

Does the applicant have a Living Will? _____

Please supply these documents to Social Services before or upon admission.

Applicants LOCAL Physician _____

PHARMACY: PICK ONE. . . . Parkview _____ Goltz _____ (These pharmacies provide medications delivered to us on a "card" system.) Medicare Part A residents **must** use Goltz. (May switch when Part A coverage is discontinued)

Has the applicant had a hospitalization or been covered under Medicare Part A in the last 30 days? _____ Dates: _____

Have you ever had a stay at another Skilled Nursing Facility (nursing home) Where? _____ When? _____

Dentist: _____ Eye doctor: _____ Foot doctor: _____

Hearing aide? If yes, where service? _____

INSURANCE INFORMATION:

Insurance Company _____ **Please provide copy of applicant's Insurance card before or upon admission.**

Have you ever been convicted of a crime? Yes _____ No _____ (Must select Yes or No to be considered for admission to Sauer Health Care)

If Yes, please choose one of the following:

- ___ Drug Related Crime
- ___ Sex Related Crime
- ___ Child Abuse Crime
- ___ Violent Crime
- ___ Domestic Abuse Crime
- ___ Other (please specify): _____

NEITHER THE APPLICANT NOR AUTHORIZED PERSON COMPLETING THIS FORM IS UNDER ANY OBLIGATION.

Sauer Health Care is operated in accordance with U.S. Department of Agriculture policy which does not permit discrimination because of Race, Color, Sex, Age, Sexual Orientation, Handicap, or National Origin. Any person who believes that he or she has been discriminated against in any USDSA-related activity should write immediately to the Secretary of Agriculture, Washington, D.C. 20250

Residents admitted after May 1, 1993 are not allowed to smoke in our facility. Designated outside areas are available for this purpose.

APPLICANT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE _____

RELATIONSHIP _____ **DATE** _____