Legacy Square

1621 Front St. - Henderson, NE. 68371 - Phone: 402-723-5301 - Fax: 402-723-4516

APPLICATION FOR ADMISSION TO LEGACY SQUARE

I hereby apply for admission, as a resident, to Legacy Square. If admitted I agree to comply with the rules and regulations of Legacy Square, including the No Smoking Policy.

I understand that the Henderson Legacy Square is licensed as a Long-term Care extension of Henderson Health Care, Inc. Legacy Square is certified for Medicaid and licensed by the State of Nebraska. Staffing and services are in accordance with the requirements enforced by the State and Federal regulations. A pre-admission screening will be given prior to admission. All information enclosed will be treated confidential.

First, Middle & Last Name of Applicant:_____

Address:_____

Home Phone:_____ Cell Phone:_____

Date of Birth:_____ Birth Place:_____

Marital Status:_____ Spouse's Name:_____

Previous Occupation:_____

Children's Information:

1._____ Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail Address:_____

2._____ Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail Address:_____

3._____ Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail Address:_____

4._____ Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail Address:_____

5._____ Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail Address:_____

6._____ Address:_____

Home Phone:_____ Cell Phone:_____

Work Phone:_____ E-Mail Address:_____

Power Of Attorney for Health Care:_____

Successor for Power of Attorney for Health Care:_____

Power of Attorney for Finances:_____

I agree to use the Henderson Health Care Physicians Yes:_____ No:_____

Primary Physician:_____

Dentist:_____ Phone:_____

Address:_____

Optometrist:_____ Phone:_____

Address:_____

Religion:_____

Applicant's Church:_____

Address:_____ Phone:_____

Mortuary:_____

Address:_____ Phone:_____

Education Level:_____ Living Will:_____

Social Security Number:_____

Circle Source of Payment: Private Pay or Medicaid

Medicare Number:_____ Medicaid Number:_____

Supplemental Insurance & Policy Number:_____

Nursing Home Insurance & Policy Number:_____

Diagnosis:_____

_____

_____

_____

_____

Current Medications:_____

_____

_____

_____

_____

Any Known Allergies:_____

Behavioral Problems:_____

_____

Activities of Daily Living: _____

_____

_____

_____

Height:_____ Weight:_____

Last Flu Vaccine:_____ Last TB Test:_____

Last Pneumococcal Vaccine:_____

Date of Pertussis Immunization, if received:_____

Room charges are based on the resident's level of care. The resident or responsible party agrees to pay, in advance, the daily rate for services to Legacy Square. Services are billed monthly. Any extra charges, such as transfer to appointments, will be billed after services.

I hereby certify that I have carefully completed this application and understand the information presented; that I have answered correctly all questions herein to the best of my knowledge.

_____

Signature of Applicant or Power of Attorney Date

_____

Witness Date