



WAITING LIST APPLICATION

GENERAL INFORMATION

APPLICANT NAME: _____
LAST (MAIDEN) FIRST MIDDLE

SOCIAL SECURITY #: _____ MARITAL STATUS: _____

EMAIL ADDRESS: _____ HOME _____ CELL _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____ PRIMARY LANGUAGE: _____
CITY/STATE

HIGHEST LEVEL OF EDUCATION OBTAINED: _____ CITIZENSHIP: _____ RELIGION: _____

PREVIOUS OCCUPATION: _____ RETIREMENT/ LAST DAY WORKED: _____

CURRENT ADDRESS (PLEASE INCLUDE NAME OF NURSING HOME IF APPLICABLE):

_____ HOW LONG AT THIS ADDRESS? _____

PREVIOUS LIVING ARRANGEMENTS IN THE PAST FIVE YEARS:

POWER OF ATTORNEY

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE: (H) _____ (C) _____ EMAIL _____

EMERGENCY CONTACTS

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE: (H) _____ (C) _____ EMAIL _____

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE: (H) _____ (C) _____ EMAIL _____

NAME _____ RELATIONSHIP _____

ADDRESS _____

PHONE: (H) _____ (C) _____ EMAIL _____

MEDICAL INFORMATION

PRIMARY DIAGNOSIS _____

OTHER DIAGNOSES _____

PRIMARY PHYSICIAN _____ HOSPITAL OF CHOICE _____

PLEASE LIST ALL SPECIALISTS APPLICANT HAS ROUTINE VISITS WITH:

NAME _____ SPECIALTY _____ NAME _____ SPECIALTY _____

NAME _____ SPECIALTY _____ NAME _____ SPECIALTY _____

NAME _____ SPECIALTY _____ NAME _____ SPECIALTY _____

LIST ALL INPATIENT STAYS WITHIN THE LAST FIVE YEARS (I.E. MEDICAL, SURGICAL, REHAB, PSYCH):

LOCATION: _____ DATE: _____ ADMITTING DIAGNOSIS: _____

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LOCATION: _____ DATE: _____ ADMITTING DIAGNOSIS: _____

LOCATION: _____ DATE: _____ ADMITTING DIAGNOSIS: _____

ASSISTANCE AND DAILY ROUTINE

DOES THE APPLICANT NEED ASSISTANCE WITH:

TOILETING	YES	NO	N/A	BATHING	YES	NO	N/A
DRESSING	YES	NO	N/A	EATING/DRINKING	YES	NO	N/A
GROOMING	YES	NO	N/A	REPOSITIONING	YES	NO	N/A
WALKING	YES	NO	N/A	TRANSFERRING	YES	NO	N/A

DOES THE APPLICANT:

HAVE A FEEDING TUBE? YES NO N/A

HAVE SIGNS OF MEMORY LOSS/COGNITIVE IMPAIRMENT? YES NO

ABLE TO AMBULATE WITH ASSISTIVE DEVICE? YES NO

USE ADAPTIVE EQUIPMENT? YES NO

FALLEN OR LOST THEIR BALANCE IN THE LAST 30 DAYS? YES NO

HAVE A LEFT OR RIGHT SIDE WEAKNESS? YES NO

DESCRIBE A TYPICAL DAY FOR THE APPLICANT

FOR PLANNING PURPOSES ONLY (NOT BINDING)

APPLICANT EXPECTS TO BE READY TO MOVE INTO THE BEECHWOOD HOME ON OR AFTER _____.
(MONTH AND YEAR)

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS

- | | | |
|--|-----|----|
| 1. HAS THE APPLICANT RECEIVED A COVID-19 VACCINE? | YES | NO |
| 2. HAS THE APPLICANT PREVIOUSLY BEEN DIAGNOSED WITH COVID-19? | YES | NO |
| 3. DOES THE APPLICANT HAVE ANY SWALLOWING ISSUES? | YES | NO |
| 4. HAS APPLICANT EVER ATTEMPTED TO WANDER AWAY FROM RESIDENCE? | YES | NO |
| 5. DOES APPLICANT EXHIBIT EXIT SEEKING BEHAVIOR? | YES | NO |
| 6. IS THE APPLICANT A CONVICTED SEXUAL OFFENDER? | YES | NO |
| 7. DOES APPLICANT CURRENTLY SMOKE? | YES | NO |
| 8. DID THE APPLICANT SMOKE IN THE PAST? | YES | NO |
| | | |
| 9. DOES THE APPLICANT CURRENTLY CONSUME ALCOHOL? | YES | NO |
| | | |
| 10. DOES THE APPLICANT HAVE A HISTORY OF RECREATIONAL/PRESCRIPTION DRUG ABUSE? | YES | NO |
| 11. DOES THE APPLICANT HAVE A VALID DRIVER'S LICENSE? | YES | NO |
| 12. DOES THE APPLICANT CURRENTLY DRIVE A MOTOR VEHICLE? | YES | NO |
| 13. DOES THE APPLICANT OWN A WHEELCHAIR? | YES | NO |
| | | |
| 14. DOES THE APPLICANT HAVE A METRO ACCESS PASS? | YES | NO |
| 15. DOES THE APPLICANT ATTEND ANY COMMUNITY AND/OR DAY WORKSHOPS? | YES | NO |
| 16. DOES THE APPLICANT HAVE A TRACHEOSTOMY? | YES | NO |
| 17. DOES THE APPLICANT HAVE ANY WOUND OR SKIN ISSUES? | YES | NO |
| 18. HAS THE APPLICANT EVER HAD AN INPATIENT ADMISSION TO PSYCHIATRIC UNIT? | YES | NO |
| 19. DOES THE APPLICANT HAVE A HISTORY OF VERBAL/PHYSICAL AGGRESSION TOWARDS
TOWARDS OTHERS? | YES | NO |

FINANCIAL INFORMATION

- | | | |
|--|-----|----|
| • CAN THE APPLICANT MEET THE PRIVATE PAY RATE OF \$345.00 A DAY | YES | NO |
| • IS THE APPLICANT SERVICE CONNECTED WITH THE VA? | YES | NO |
| • DOES THE APPLICANT HAVE A QUALIFIED INCOME TRUST? | YES | NO |
| * In 2021, if your income is more than \$2,382 per month, you will need a QIT to qualify for Ohio Medicaid | | |
| • DOES THE APPLICANT RECEIVE A PENSION, PRIVATE, LOCAL, STATE OR FEDERAL AID INCLUDING
SOCIAL SECURITY? IF YES, PLEASE SPECIFY: | | |

SOURCE	AMOUNT	IDENTIFICATION NUMBER

INSURANCE COVERAGE

- | | | | | | |
|-------------------------|-----|----|--------------|--------|-----------------------------------|
| -MEDICAID | YES | NO | PENDING | NUMBER | _____ |
| -TRADITIONAL MEDICARE | YES | NO | NUMBER | _____ | A EFF DATE _____ B EFF DATE _____ |
| -MANAGED MEDICARE | YES | NO | COMPANY | _____ | NUMBER _____ |
| -MY CARE OHIO PLAN | YES | NO | COMPANY | _____ | "DUAL" OR "MEDICAID ONLY" |
| -MEDICARE PRESCRIPTION | YES | NO | COMPANY NAME | _____ | NUMBER _____ |
| -LIFE INSURANCE POLICY? | YES | NO | | | |
| -LONG-TERM CARE POLICY? | YES | NO | | | |
| - OTHER INSURANCE | YES | NO | PROVIDER | _____ | NUMBER _____ |

PLEASE INCLUDE COPIES OF INSURANCE CARDS WITH APPLICATION

THE BEECHWOOD HOME WAITING LIST DISCLOSURES

The Beechwood Home is an open concept facility that allows residents to travel throughout the facility. The facility does not have a secured unit thus is not appropriate for individuals who have a history of exit seeking behaviors or have an identifiable safety concern related to the building design.

The Beechwood Home is a non-smoking facility. Residents are not permitted to smoke in the facility, on facility sponsored activities, or on the facility grounds.

Residents are not permitted to have smoking/drug paraphernalia in their possession, including E-Cigarettes.

Failure to comply with the smoking policy will result in discharge from the facility.

Scooters are not permitted in the facility due to safety concerns. Manual and custom electric wheelchairs are permitted.

Due to The Beechwood Home being adjacent to a school, sexual offenders are not permitted to be admitted.

Applicants will be added to the waiting list upon receipt of a completed application. Placement on the waiting list does not guarantee or assure admission. Admission decisions are made utilizing the discretion of the Admission Committee and are made taking into consideration current conditions, situations, needs, financial/medical information and other pertinent data.

On an annual basis, applicants will be asked to update contact, medical and financial information by completing the current years waiting list application. Applications will be sent to the address on file. If the applicant chooses to remain on the waiting list, the application will need to be completed and submitted within 60 days. Failure to respond within 60 days may result in the applicant being removed from the waiting list.

At the time an applicant is actively being considered for admission, additional information will be requested for review by the Admission Committee. This information will include but may not be limited to medical, psychosocial, financial and functional status.

To the best of my knowledge, the information on this application is truthful, complete and accurate.

Signature

Date

***Hit SUBMIT or return paper copy to Admission Coordinator Heather Hefren**

**2140 Pogue Avenue, Cincinnati, OH 45208
@ 513-533-6413 (fax)**