Resident Name: ___________________________________

2025 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____

Responsible Party's Initials ________

Resident Name: ___________________________________

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:________________________

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? NO YES, HOW FAR?_____________________________________

USE ADAPTIVE EQUIPMENT? NO YES, WHAT KIND?____

FALLEN OR LOST THEIR BALANCE IN THE LAST 30 DAYS? NO YES, HOW MANY TIMES?___________________

HAVE A LEFT OR RIGHT SIDE WEAKNESS? NO YES, WHICH SIDE?_______________________________________

DESCRIBE A TYPICAL DAY FOR THE APPLICANT

____
____
____
____

FOR PLANNING PURPOSES ONLY (NOT BINDING)

Responsible Party’s Initials ________

Resident Name: ____________________________________

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. DOES THE APPLICANT HAVE ANY SWALLOWING ISSUES? YES NO
3. HAS APPLICANT EVER ATTEMPTED TO WANDER AWAY FROM RESIDENCE? YES NO
4. DOES APPLICANT EXHIBIT EXIT SEEKING BEHAVIOR? YES NO
5. IS THE APPLICANT A CONVICTED SEXUAL OFFENDER? YES NO
6. DOES APPLICANT CURRENTLY SMOKE? YES NO
7. DID THE APPLICANT SMOKE IN THE PAST? YES NO
   IF YES, DATE OF LAST CIGARETTE? ___________________________
8. DOES THE APPLICANT CURRENTLY CONSUME ALCOHOL? YES NO
   IF YES, HOW MUCH/HOW OFTEN? ________________________________
9. DOES THE APPLICANT HAVE A HISTORY OF RECREATIONAL/PRESCRIPTION DRUG ABUSE? YES NO
10. DOES THE APPLICANT HAVE A VALID DRIVER'S LICENSE? YES NO
11. DOES THE APPLICANT CURRENTLY DRIVE A MOTOR VEHICLE? YES NO
12. DOES THE APPLICANT OWN A WHEELCHAIR? YES NO
    IF YES, MANUAL/POWER/SCOOTER? _______________________________
    IF YES, HOW OLD IS THE WHEELCHAIR? _____________________________
    IF YES, DID MEDICAID PAY FOR THE WHEELCHAIR? ____________________
13. DOES THE APPLICANT HAVE A METRO ACCESS PASS? YES NO
14. DOES THE APPLICANT ATTEND ANY COMMUNITY AND/OR DAY WORKSHOPS? YES NO
15. DOES THE APPLICANT HAVE A TRACHEOSTOMY? YES NO
16. DOES THE APPLICANT HAVE ANY WOUND OR SKIN ISSUES? YES NO
17. HAS THE APPLICANT EVER HAD AN INPATIENT ADMISSION TO PSYCHIATRIC UNIT? YES NO
18. DOES THE APPLICANT HAVE A HISTORY OF VERBAL/PHYSICAL AGGRESSION TOWARDS OTHERS? YES NO

FINANCIAL INFORMATION

- CAN THE APPLICANT MEET THE PRIVATE PAY RATE OF $385.00 A DAY YES NO
- IS THE APPLICANT A VETERAN? IF YES, YEARS SERVED? YES NO ____________
- IS THE APPLICANT SERVICE CONNECTED (70% OR MORE) WITH THE VA FOR LTC? YES NO
- DOES THE APPLICANT HAVE A QUALIFIED INCOME TRUST? YES NO
  *In 2025, if your income is more than $2,901 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 _______________

- OTHER INSURANCE YES NO PROVIDER _____________________________ NUMBER____________

Responsible Party's Initials _________

Resident Name: ___________________________________

PLEASE INCLUDE COPIES OF INSURANCE CARDS WITH APPLICATION

HOW WOULD ADMISSION TO THE BEECHWOOD HOME IMPROVE QUALITY OF LIFE FOR THE APPLICANT?:

____
____
____
____
____
____
____
____
____

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.

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

Responsible Party's Initials ________

Resident Name: ___________________________________

*Please return to 513-533-6413 (fax) or admissions@beechwoodhome.com

FINANCIAL DISCLOSURE

We thank you for considering The Beechwood Home. To aid us in assessing whether we can meet your financial needs, we would like to review your financial resources to pay for care. Once determined, we can then establish a clear understanding of the financial responsibility you will be undertaking. Additional financial data (such as bank statements) may be requested.

We require this information of all residents, regardless of their method of payment or length of stay. All information will be kept confidential, and if you choose our facility, this form will become part of your admission agreement.

General Information:

Prospective Resident's Name: ____

If you are not the prospective resident:

Your Name: ______________________________ Relationship ______________________

Prospective Resident’s Spouse: ____

Legal Representatives:

Please provide agreements designating each legal representative. (Example: Legal guardian, POA, DPOA, Guarantor, Responsible party)

Type of legal representative* ____

Name: ___________________________________ Telephone (day/eve): ________________

Address: _________________________________ Title or relationship to resident: _______

____

Type of legal representative* ____

Name: ___________________________________ Telephone (day/eve): ________________

Address: _________________________________ Title or relationship to resident: _______

____

Financial Information:

Does the resident have any insurance that will cover care provided in a long-term care facility, or residential care facility? YES NO

If yes, please identify:

Company: ________________________________ Policy #: ________________________________

Address: ____

Responsible Party’s Initials ________

Resident Name: ___________________________________

Agent's Name: ____________________________ Telephone #: _____________________________

Responsible Party's Initials ________

Financial Information Continued:

Monthly Income:

Salary $ ___________________ Social Security check $ ___________________
Pension $ ___________________ IRA $ ___________________
Annuity $ ___________________ Disability check $ ___________________
Rental income $ ___________________ Other $ ___________________

Total income – All sources $ _________________________________

Cash Assets:

Bank (1) ___________________________ Location __________________________________

Checking account ___________________ Balance in account $ ____________

Savings account ____________________ Balance in account $ ____________

Certificates of Deposit? NO ___ YES _____ If yes, approximate amount $ ____________

Bank (2) ___________________________ Location __________________________________

Checking account ___________________ Balance in account $ ____________

Savings account ____________________ Balance in account $ ____________

Certificates of Deposit? NO ___ YES _____ If yes, approximate amount $ ____________

Bank (3) ___________________________ Location __________________________________

Checking account ___________________ Balance in account $ ____________

Savings account ____________________ Balance in account $ ____________

Certificates of Deposit? NO ___ YES _____ If yes, approximate amount $ ____________

(If there are additional cash assets, which require additional space, please list the location of these assets and the amount on a separate sheet and attach to this financial disclosure.)

Total of all cash assets listed $____

Real Estate Assets:

Does the resident own a home? No ___ Yes ___________ If yes, approximate value $ ____
Does resident own any other property? No ___ Yes ___________ If yes, approximate value $ ____

If yes, what and where is property located? ____

Total value of all properties owned $ _________________________________

Responsible Party's Initials _________

Resident Name: ___________________________________

Financial Information Continued:

Life Insurance Cash value:

Does resident have life insurance policies with cash value? No ___ Yes ___

Company Name: ___________________ Approximate amount of cash value $ _________

Agent Name: ______________________ Telephone _______________________________

Annuities $ _________________________

(If life insurance is held by more than one agent, please list agents and the amount they handle on a separate sheet and attach to this financial disclosure.)

Total of all cash values listed $ ________________________________

Securities:

Does the resident have stocks and bonds? No ____ Yes ____

Approximate current market value of all securities $ ________________________________

Agent handling securities _________________________ Telephone _________________

Address: ____

(If more than one agent holds securities, please list these agents and the amount they handle on a separate sheet and attach to this financial disclosure.)

Assets Transferred To Or Held In Trust:

Identify assets held in Trust: ____

On what date were assets transferred to Trust?: ____

Approximate value of assets held in Trust: ____

[Require Prospective Resident to Produce Copy of Trust Agreement]

Other:

Are there any other sources of income that have not been identified above? No _____ Yes ____

Please identify the source(s): ____

____

Approximate current market value of these sources $ ________________________________

Other Transfers:

Have you or your spouse made gifts of cash or real property in excess of $1500 or sold assets for less than fair market value in the last five years ? If yes, please explain.

Responsible Party's Initials ________

Resident Name: ____________________________________

Summary of Income and Assets:

Total available sources of income:

Monthly income	$ __________________________	
Annuities	$ __________________________	
Total sources of income	**$ __________________________**	**(A)**

Total available sources of assets:

Bank (1)	**$ __________________________**	
Bank (2)	**$ __________________________**	
Bank (3)	**$ __________________________**	
Real Estate Assets	**$ __________________________**	
Life Insurance cash value	**$ __________________________**	
Securities	**$ __________________________**	
Other	**$ __________________________**	
Total Assets	**$ __________________________**	**(B)**

Responsible Party's Initials ________

Financial Information Continued:

From what source(s) does the resident plan to pay for services at the Facility (named on agreement)?

____

____

If necessary, would the resident be willing to liquidate his/her assets to pay for services at the facility?
No ____ Yes ____

If the resident's resources become insufficient to meet total expenses while residing at the Facility, are there other persons or organizations that could help pay for services? If yes, please specify.

____

____

Are there any safeguards to ensure that your resources are used only for the resident's benefit? If yes, please specify.

____

____

During the past five years, has the resident given or transferred any cash, property or other assets (valued at more than $1,000) to any person or organization? If yes, please specify when, to whom, what assets and what their total value was at the time of transfer.

____

____

Who will handle the resident's financial affairs while he/she is a resident at the Facility (named in agreement)?

Name: ____________________________ Relationship ____________________________________

Address: __________________________ Legal Relationship _______________________________

__________________________ Telephone ______________________________________

In the past seven years has the resident declared bankruptcy or had judgments against them?
No ____ Yes ____

If yes, please specify: ____

____

Resident Name: ___________________________________

Financial Information Continued:

Liabilities:

Please list any balance owed by the resident on the items below:

House Loans	$ __________________	**Medical Expenses**:	
Credit Cards	$ __________________	Doctor	$ _________________________
Automobiles	$ __________________	Prescriptions	$ _________________________
Notes	$ __________________	Hospital	$ _________________________

Total Liabilities **$ _______________________________ (C)**

Estimate of residual assets:

Monthly Income $ _______________________________ (A)

Total Assets $ _______________________________ (B)

- Total Liabilities $_______________________________ (C)

Residual Assets $ _______________________________

Authorization:

I hereby state that to the best of my knowledge, the information on this form is true, accurate and complete. I understand that if any information has been falsely represented, it may be sufficient cause for denying admission or discharging the resident from the center. I authorize the Facility (named in the agreement) to investigate financial and credit records through any investigative or credit agency(s) of it's choice.

Resident: ____ Date: _______________

Legal Representative: ____ Date: _______________
Legal Guardian, POA, DPOA

Responsible Party/Agent: ______________________________________ Date: _______________

Facility Representative: _______________________________________ Date: _______________

Witness*: ____ Date: _______________

Witness*: ____ Date: _______________

*** Required only if resident is unable to sign his/her full name.**

*Please return to 513-533-6413 (fax) or admissions@beechwoodhome.com

Responsible Party's Initials ________