Resident Name: _____

2026 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_____

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:_____

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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)

APPLICANT EXPECTS TO BE READY TO MOVE INTO THE BEECHWOOD HOME ON OR AFTER _____.

(MONTH AND YEAR)

Responsible Party's Initials _____

Resident Name: _____

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 $400.00 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 2026, if your income is more than $2,982 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_____

PLEASE INCLUDE COPIES OF INSURANCE CARDS WITH APPLICATION

Responsible Party's Initials _____

Resident Name: _____

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

_____
_____
_____
_____
_____
_____
_____
_____
_____

How did you hear about us? _____

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

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

Responsible Party's Initials _____