

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 _____

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)

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" <u>OR</u> "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 _____

Resident Name: _____

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, YES NO
or residential care facility?

If yes, please identify:

Company: _____

Policy #: _____

Address: _____

Agent's Name: _____

Telephone #: _____

Responsible Party's Initials _____

Resident Name: _____

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 _____

Resident Name: _____

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: _____

Responsible Party's Initials _____

Resident Name: _____

Financial Information Continued:

Liabilities:

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

House Loans \$ _____

Credit Cards \$ _____

Automobiles \$ _____

Notes \$ _____

Medical Expenses:

Doctor \$ _____

Prescriptions \$ _____

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: _____
Legal Guardian, POA, DPOA

Date: _____

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 _____