St. Elizabeth Briarbank Assisted Living for Women
39315 Woodward Avenue
Bloomfield Hills, MI 48304

Date_____________________

Please indicate how you came to hear of St. Elizabeth Briarbank____

PLANNED DATE OF ADMISSION____

Information requested is required to evaluate the applicant's request for residency. All information submitted will be held in the strictest confidence and according to HIPPA guidelines. The acceptance of this form does not bind either party to admission.

PERSONAL INFORMATION:

Last Name:	First Name:	Middle or Maiden Name:
Address:	City:	ZIP and County
Phone:	Former Occupation:	
Date of Birth:	Place of Birth:	
Sex:	Marital Status: (circle) Single Married Divorced Widowed	
Social Security #:	Medicare #: Does Applicant Have Medicare Part B? Medicare Part D Provider and Number:	Supplemental Insurance Provider including identifying numbers:
Religious Affiliation:	Name and phone number of Minister, Priest or Rabbi:	

Emergency Contacts

Full Name:	Relationship:	Address: Phone Numbers:
Full Name:	Relationship:	Address: Phone Numbers:
Full Name:	Relationship:	Address: Phone Numbers:

Legal Guardian/Power of Attorney (paperwork required if admitted to St. Elizabeth)		
Full Name:	Relationship:	Address: Phone
Full Name:	Relationship:	Address: Phone
Person Responsible for Payment of Care		
Full Name:	Address	Phone Numbers:
Person(s) Responsible for Personal Needs and Transportation to Physician, Dentists, etc.		
Full Name:	Address	Phone:
Full Name:	Address	Phone:
Physician(s)		
Full Name:	Address	Phone: Fax:
Full Name:	Address	Phone: Fax:
General State of Health of Applicant:		
Allergies: Is the applicant allergic to medications? Food? Other allergies? If none, state "No allergies"		

List All Medications Currently Being Taken by Applicant, include purpose	
Medication Name	**Purpose of Medication**

Medication Name	Purpose of Medication

Identify Any Physical Limitation (walker, vision impairment, hearing aid, etc). If none, state none.

Does the applicant have special diet requirements? If none, state none.

Emergency Information – In the event of serious illness or death, what is your preference?

Hospital Name	Address:	Phone Numbers:
Funeral Home Name	Address;	Phone Numbers: Fax Number:

Children and/or Relatives

Full Name:	Address	Phone Numbers:
Full Name:	Address	Phone Numbers:
Full Name:	Address	Phone Numbers:
Full Name:	Address	Phone Numbers:

Applicant's Sources of Income and Amount

Social Security $	Interest Income$	Insurance Income $
Pension $	Rental Income $	Stocks/Bonds $
Family Support $	Disability Income $	Other Income $

Residence Prior to Admission to St. Elizabeth Briarbank (check one)

	Own Home

	Senior Home or Apartment
	Rehabilitation Facility: Include name, address, phone numbers (include fax) and contact person
	Assisted Living Facility: Include name, address, phone numbers (include fax) and contact person
	Other:

My signature below certifies that the information provided in this application is accurate.

____

Printed Name **Signature** **Date**

Office Use Only (check if submitted by applicant)	
	Planned Date of Admission
	Chest X-ray or TB Screening including date
	Physician Report
	Assessment Plan for Residents
	Medication List signed by physician
	Durable Medical Power Of Attorney
	Advanced Directive or Living Will (DNR)
	Legal Guardian or Authorized Representative Documentation
	Funeral Home Identified