THE WASHINGTON HOME

Quality Healthcare Since 1888

3720 Upton Street NW
Washington, DC 20016
202-895-0182
202-895-0306 (fax)

Application for Admission

The following information will be used to determine eligibility for admission. The person signing this document represents that all information is true, accurate and complete. If the information changes prior to the date of admission, you must notify The Washington Home in writing of all changes.

GENERAL INFORMATION

Name ________________________________

Maiden ________________ Sex: ❑ M ❑ F

Home Address ________________________________

________________ Phone ________________

How long at this address ____________ How long a DC resident ____________

Social Security # ________________________________

Date of Birth ________________ Place of Birth ________________

Marital States: ❑ single ❑ married ❑ separated ❑ widowed ❑ divorced
if divorced, provide copy of decree, does it provide for support? ________________

Name of Spouse (If married or separated) ________________________

Current living arrangements ❑ self ❑ home w/ assistance ❑ w/family ❑ other facility

Previous Occupation ________________________________

Citizenship (must provide copy of birth certificate or passport) ________________

Primary Language ____________ Race ________ Years of Schooling________

Does applicant have: (Please attach copies)

Conservator/Guardianship:
Name ________________ Relationship ________________

Power of Attorney:
Name ________________ Relationship ________________

Durable Power of Attorney for Health Care:
Name ________________ Relationship ________________

Living Will:

Name ______________________ Relationship ______________________

Do advanced directives exist for organ donation or autopsy request? ______________________

(Please attach copy)

Mortuary Preference:

Name ______________________ Phone ______________________

Address ______________________

Are there prepaid funeral arrangements: ______________________

Religious Affiliation: ______________________

Clergy Name ______________________ Phone ______________________

Current Physician:

Name ______________________ Phone ______________________

Address ______________________

His decision is:

❏ Will continue to serve as physician for applicant

❏ Would like your care transferred to The Washington Home Staff

❏ Has recommended a physician:

Name ______________________ Phone ______________________

Address ______________________

If the applicant is coming from an acute hospital or nursing home please complete:

Facility's Name ______________________ Phone ______________________

Address ______________________

Date of Admission: ______________________ Discharge: ______________________

Reason for transfer from other nursing home: ______________________

Has the applicant been in any other hospital or nursing home in the past year?

Facility: ______________________

Date of Admission: ______________________ Discharge: ______________________

Facility: ______________________

Date of Admission: ______________________ Discharge: ______________________

Nearest Relative Name: ______________________________

Address: ______________________________

Phone # (Home): ____________________ (Work): ____________________

Relationship to Applicant: ______________________________

Notify in case of emergency: ______________________________

Address: ______________________________

Phone # (Home): ____________________ (Work): ____________________

Relationship to Applicant: ______________________________

Responsible Party for Insurance: ______________________________

Address: ______________________________

Phone # (Home) ____________________ (Work): ____________________

Relationship to Applicant: ______________________________

Insurance Information (Please attach copies of each)

Medicare#: ____________________ Effective Date: ____________________

Hospital ____________________ Medical ____________________

Medicaid#: ____________________ Effective Date: ____________________

Level of Care: ____________________ Dates from __________ to __________

Other Health Insurance:

Name: ____________________ Policy # ____________________

Name: ____________________ Policy # ____________________

Referred to The Washington Home by: ______________________________

I certify to the best of my knowledge everything on this application is true, accurate and complete.
Signature of Applicant required unless physician has completed signature waiver form

Date ______________________________

Signature of Applicant or Responsible Party ______________________________

The Washington Home complies with the title VI Civil Rights Act of 1964