140-051

Birmingham Green
Nursing Facility 8605 Centreville Rd, Manassas, VA 20110
Willow Oaks and the District Home, Centreville Rd, Manassas, VA 20110
ADMISSION OFFICE 703-257-6206, FAX 703-257-6242

NH _____ ALF_____

Facility Use Only

Date of Application ____________
Date of Admission ____________
Resident Number ____________
Room Number ____________

Last Name	First Name	Middle	Sex	Age	Birth date	Birth Place		Education
Current Address	Street	City	State	Zip	County	Marital Status		Spouse Name
						S M W DIV		
Previous Address	Street	City	State	Zip	County	Occupation		Military Branch

Social Security #	Medicare Number	Effective Date	Medicare D Plan Name	ID Number:
		Part A:		Group Number:
		Part B:		RxBin: RxPCN:

Transferring NH / ALF Name/Phone #	Medicaid Number	Other Insurance Plan(s)	Other Insurance ID Number(s)

Religion	Name/Address/Phone Clergy/Place of Worship	Funeral Home/Address/Phone	US Citizenship
			Yes: ______ No: ______ Other Country:

Name of Responsible Party	Address	Home Phone	Work Phone	Cell Phone	Email
Name of Emergency Contact	Address	Home Phone	Work Phone	Cell Phone	Email

Hearing: Good/Poo	Hearing Aid: Yes/No	Eyeglasses:	Dentures: Yes/No if yes, Full/Partial	Wanders: Yes/No/At Times
Bowel Control: Yes	Bladder Control: Yes/No	Speech : Good/Unclear/None	Primary Language:	
Walks: Alone/Cane/Walker/Does Not Walk		Equipment Used: Wheelchair/Geri-chair/Oversized Bed/Electric WC/Other:		
Informant's Name:		Case Manager/ Social Worker's Name:		Phone:

PLEASE COMPLETE B OTH SIDES OF THIS FORM AND SIGN ON THE BACK

Birmingham Green does not discriminate against any adult on the basis of race, color, national origin, disability or age in admission, treatment, or participation in its programs, services and activitivies or in employment. For further information about this policy contact: Kar Human Resources at:

ADMISSION APPLICATION - Page 2

Advance Directives:	If Yes, list Name Address	Home Phone		Work Phone
Medical Power of Attorney: Yes/No				
Financial Power of Attorney: Yes/No				
Legal Guardian: Yes/No				
Living Will: Yes/No	Durable Do Not Resuscitate Form: Yes/No	*Please attach all pertinent documentation*		
Special Burial Arrangements (e.g. organ donation):				

Psychiatrist /Group Practice's Name and Psychotherapist Providing Outpatient Treatment:	Phone Number	Release Signed
		Yes/No
Community Services Board Providing Outpatient Treatment:	Phone Number	Release Signed
Therapist's and/or Psychiatrist's Name:		Yes/No
		Release Signed

Date of Last Medical Hospitalization:	Name of Hospital:	Yes/No
Date of Last Psychiatric Hospitalization:	Name of Hospital:	Yes/No

Medications (see UAI or H&P)	History of Substance Abuse (if applicable)
Current Behavioral/Social Problems or Strengths:	

Significant Others Name/Relation	Address	Home Phone	Work Phone		Cell Phone

Physician Name	Address	Work Phone	Other Physician's Name(dentist, etc.)

Special Interests and Hobbies:

I HAVE RECEIVED A COPY OF THE DISCLOSURE STATEMENT WITH THIS APPLICATION (FOR ASSISTED LIVING APPLICANTS ONLY)
I HAVE BEEN INFORMED REGARDING THE SEXUAL OFFENDER REGISTER AND UNDERSTAND AI ALL APPL CANTS ARE SCREENED

SIGNATURE OF APPLICANT/RESPONSIBLE PARTY: ______________________________

DATE: ____________

ATTESTATION SIGNATURE: By signing below, I attest that the prospective applicant has not been arrested or convicted of a barrier crime in any state, as described by federal code.

ATTESTATION SIGNATURE: ______________________________ **DATE:** ____________