Park View Health Center
Over a Century of Quality Care

725 Butler Avenue
Oshkosh, WI 54901-8149
920-237-6300
920-727-2883
Fax: 920-237-6944

APPLICATION FOR ADMISSION

Name: _____
(Last) (First) (Middle)

Home Address: _____
(Street) (City) (State/Zip)

Home Phone: (____) _____ Cell Phone: (___) _____

County & State of Legal Residence: _____

Date of Birth:_____ Age: _____ Race: _____

Marital Status:_____Gender: ☐ F ☐ M Name of Spouse: _____

Religion:_____Church:_____ Address:_____

Non-Emergency Ambulance Transportation Preference: ☐ Oshkosh Fire Dept
☐ Gold Cross Ambulance

Choice of Funeral Home:_____ Address:_____

Are you a Veteran? ☐ Yes ☐ No Is your spouse a veteran? ☐ Yes ☐ No

Name of Primary Physician: _____ Phone: (____)_____

Hospital Preference:_____

Name of Dentist: _____ Phone:(____)_____

Name of Eye Doctor: _____ Phone:(____)_____

Primary diagnosis/health concerns at this time:_____

Desired date of Admission to nursing home: _____

What is the anticipated length of stay? ☐ Short term ☐ Long term ☐ Uncertain
Has applicant ever lived in a nursing home, CBRF, or group home? ☐ Yes ☐ No
If yes - Facility Name/Dates:_____

LEGAL DOCUMENTS *(check all that apply)*

☐ Power of Attorney for Health Care ☐ Financial Power of Attorney ☐ Living Will
☐ Guardian of Person ☐ Guardian of Estate ☐ Protective Placement

A COPY OF INSURANCE CARDS AND LEGAL PAPERS REQUIRED

FINANCIAL STATEMENT

Monthly Income *(check all that apply)***:**

☐ Social Security ☐ SSI ☐ Veteran's Benefits ☐ Pensions
☐ Interest ☐ Dividends ☐ Annuities ☐ Rents ☐ Other

Assets *(Checking, Savings, Certificates, Stocks, Bonds, Real Estate, Other)***:**

☐ Under $2,000 ☐ $2,000-$50,000 ☐ Over $50,000

Medicare Number: _____ Coverage: ☐ A ☐ B

Health Insurance Primary: _____
(Name) *(Policy #)* *(Group #)*

Health Insurance Secondary: _____
(Name) *(Policy #)* *(Group #)*

Medicare D Drug Plan: _____
(Name) *(Policy #)* *(Group #)*

Social Security #: _____ Medicaid #: _____

Are you a member of Lakeland Care District? ☐ Yes ☐ No **Do you own your own home?** ☐ Yes ☐ No

The following persons, in order of priority, may be notified of my medical condition, changes in condition, care plan, transfers and pick up my possessions upon discharge:

1) Name: _____ Relationship: _____

Address: _____
(Street) *(City)* *(State/Zip)*

Work Phone: (____) _____ Home Phone: (____) _____
Cell Phone: (____) _____

2) Name: _____ Relationship: _____

Address: _____
(Street) *(City)* *(State/Zip)*

Work Phone: (____) _____ Home Phone: (____) _____
Cell Phone: (____) _____

3) Name: _____ Relationship: _____

Address: _____
(Street) *(City)* *(State/Zip)*

Work Phone: (____) _____ Home Phone: (____) _____
Cell Phone: (____) _____

Financially Responsible Person: _____
(*Name/Relationship)* *(Address)* *(Phone)*

Signed by: _____ Date: _____ Relationship: _____

PVHC 2–620 (12/21/12) ***This application is valid for one year.***