For office use only

Adm. #_____

Doctor_____

A/D_____

Room #_____

Medicare Stay_____

PT/OT_____

SAUER HEALTH CARE

1635 West Service Drive
Winona, MN 55987
(507) 454-5540
FAX (507) 454-1647

Admission Information

Date: _____

Name of Applicant_____
Last First Middle

Address_____City_____State_____Zip_____

Telephone No._____ Current Location (i.e. hospital, etc) _____ Date of Birth_____

Social Security No._____Medicare No._____
(Please supply copies of both cards)

U.S. Citizen: Yes/ No Prior Occupation:_____ Years of Education: _____

Marital Status: Single_____Married_____Widow_____Widower_____Sep_____Divorced_____

Name of Spouse_____Living_____Deceased_____ Veteran OR widow/widower of Veteran?_____

List Contacts Below: *(Please Note: This is how names will be listed in the Resident's Medical Record for all notifications)*

Cell/Work phone: _____

1. Name_____Home Phone: _____

   Address_____ Relationship:_____

Cell/Work/ phone:_____

2. Name_____Home phone: _____

   Address_____Relationship:_____

RELIGIOUS AFFILIATION:_____ Local Church_____

PREFERRED FUNERAL HOME_____Address_____Phone_____
(If left blank, Martin-Myhre F.H. of Winona will be used as holding facility)

FINANCIAL INFORMATION:

Are you currently receiving: VA_____SS_____SSI_____Medical Assistance_____

Do you have a legally appointed Guardian or Conservator? Yes No Name_____

Do you have a Power of Attorney (Financial)? Yes No Name_____

Address_____Phone_____

Do you have a Power of Attorney for Health Care? Yes No Name_____

Address_____Phone_____

Does the applicant have a Living Will?_____

Please supply these documents to Social Services before or upon admission.

Applicants **LOCAL** Physician_____

PHARMACY: **PICK ONE**. . . .Parkview_____ Goltz_____(These pharmacies provide medications delivered to us on a "card" system.) Medicare Part A residents **must** use Goltz. (May switch when Part A coverage is discontinued)

Has the applicant had a hospitalization or been covered under Medicare Part A in the last 30 days?_____ Dates:_____

Have you ever had a stay at another Skilled Nursing Facility (nursing home) Where?_____When?_____

Dentist: _____ Eye doctor:_____ Foot doctor:_____

Hearing aide? If yes, where service? _____

INSURANCE INFORMATION:

Insurance Company_____**Please provide copy of applicant's Insurance card before or upon admission.**

Have you ever been convicted of a crime? Yes____ No_____ (Must select Yes or No to be considered for admission to Sauer Health Care)

If Yes, please choose one of the following:

___ Drug Related Crime
___ Sex Related Crime
___ Child Abuse Crime
___ Violent Crime
___ Domestic Abuse Crime
___ Other (please specify):_____

NEITHER THE APPLICANT NOR AUTHORIZED PERSON COMPLETING THIS FORM IS UNDER ANY OBLIGATION.

Sauer Health Care is operated in accordance with U.S. Department of Agriculture policy which does not permit discrimination because of Race, Color, Sex, Age, Sexual Orientation, Handicap, or National Origin. Any person who believes that he or she has been discriminated against in any USDSA-related activity should write immediately to the Secretary of Agriculture, Washington, D.C. 20250

Residents admitted after May 1, l993 are not allowed to smoke in our facility. Designated outside areas are available for this purpose.

APPLICANT OR AUTHORIZED REPRESENTATIVE'S SIGNATURE_____

RELATIONSHIP_____**DATE**_____

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