New Cassel Retirement Center

APPLICATION AND EMERGENCY INFORMATION

Please complete and return in the enclosed envelope as soon as possible.

Thank you!

NEW CASSEL RETIREMENT CENTER
Emergency Information

Resident Name:_____
Prefix First Middle Last

Preferred Name:_____

MEDICAL INSURANCE

Medicare (HIC) #:_____

Blue Cross Blue Shield #:_____ Railroad Retirement #:_____

Other Health Care Policy Name_____ Policy #_____

Medicaid #:_____ Social Security #:_____-_____-_____

ADVANCE DIRECTIVES & EXTERNAL DECISION MAKERS

CPR? [ ] No [ ] Yes If no, attach Directive.

If answering YES to any of the below, attach copy to this sheet.

Financial Power of Attorney?	[ ] No [ ] Yes	Name:_____
Durable POA-Health Care?	[ ] No [ ] Yes	Name:_____
Conservator?	[ ] No [ ] Yes	Name:_____
Guardian?	[ ] No [ ] Yes	Name:_____
Funeral Arrangements?	[ ] No [ ] Yes	Mortuary:_____
Living Will?	[ ] No [ ] Yes	
Organ Donor?	[ ] No [ ] Yes	

In case of emergency, 911 will be called for an ambulance and a copy of your **Advance Directives** will be provided to emergency response personnel.

MEDICAL

Diabetic?	[ ] No [ ] Yes	
Uses Insulin?	[ ] No [ ] Yes	
History of Heart Attack?	[ ] No [ ] Yes	
Uses Nitro?	[ ] No [ ] Yes	
History of Stroke?	[ ] No [ ] Yes	
Requires Oxygen Equipment?	[ ] No [ ] Yes	If yes, name of supplier:_____
Memory Impaired?	[ ] No [ ] Yes	
Vision Impaired?	[ ] No [ ] Yes	
Hearing Impaired?	[ ] No [ ] Yes	
Ambulatory Support Device?	[ ] No [ ] Yes	□ Cane □Walker □Power Scooter □Wheelchair
Lift Chair?	[ ] No [ ] Yes	

Other Special Equipment or Needs:_____

Disability? [ ] No [ ] Yes

Do you smoke? [ ] No [ ] Yes

List all surgeries:_____

_____

Allergies? [ ] No [ ] Yes If yes, please list with reaction_____

_____

OTHER

Birthdate:_____/_____/_____ Age:_____ Sex: □ Male □ Female

Marital Status_____Religion_____

Current Address:_____
Street City State Zip

Phone #:(____)_____E-mail Address:_____

What church do you attend?_____

Veteran: Yes or No Branch _____ Conflict _____ Spouse of Veteran: Yes or No

CONTACTS

Please list (in priority) emergency contacts:

1. Name:_____
Title First Last

   Office Phone #: (_____)_____ext_____ Workplace_____

   Home Phone #: (_____)_____ Mobile #: (_____)_____

   Other Phone #: (_____)_____

   E-Mail Address:_____

   Physical Address:_____
Street City State Zip

   Relationship:_____

   HIPAA Permission: Yes____No_____to share personal health information with this person.

   HIPAA Permission: Yes____No_____to share personal financial information with this person.

□ This individual agrees to provide transportation and shelter for me in the event of an emergency evacuation.

2. Name:_____
Title First Last

   Office Phone #: (_____)_____ext_____ Workplace_____

   Home Phone #: (_____)_____ Mobile #: (_____)_____

   Other Phone #: (_____)_____

   E-Mail Address:_____

   Physical Address:_____
Street City State Zip

   Relationship:_____

   HIPAA Permission: Yes____No_____to share personal health information with this person.

   HIPAA Permission: Yes____No_____to share personal financial information with this person.

□ This individual agrees to provide transportation and shelter for me in the event of an emergency evacuation.

3. Name:_____
Title First Last

Office Phone #: (_____)_____ext_____ Workplace_____

Home Phone #: (_____)_____ Mobile #: (_____)_____

Other Phone #: (_____)_____

E-Mail Address:_____

Physical Address:_____
Street City State Zip

Relationship:_____

HIPAA Permission: Yes____No_____to share personal health information with this person.

HIPAA Permission: Yes____No_____to share personal financial information with this person.

☐ This individual agrees to provide transportation and shelter for me in the event of an emergency evacuation.

MEDICAL PROFESSIONALS

Please list all physicians, dentists, eye doctors, podiatrists, chiropractors, etc. An Omaha physician is required.

1. Doctor:_____ Address:_____
Street, City, State, Zip

Office Phone #: (_____)_____ Fax #: (_____)_____

2. Doctor:_____ Address:_____
Street, City, State, Zip

Office Phone #: (_____)_____ Fax #: (_____)_____

3. Doctor:_____ Address:_____
Street, City, State, Zip

Office Phone #: (_____)_____ Fax #: (_____)_____

4. Doctor:_____ Address:_____
Street, City, State, Zip

Office Phone #: (_____)_____ Fax #: (_____)_____

What is your hospital preference?_____

What is your ambulance preference?_____

Name of Pharmacy:_____

Pharmacy Address:_____Pharmacy Phone #:(_____)_____
Street, City, State, Zip

OTHER LIVING FAMILY MEMBERS NOT PREVIOUSLY LISTED:

1. Name:_____Relationship:_____
Title First Last

Office Phone #: (_____)_____ext_____ Workplace_____

Home Phone #: (_____)_____ Mobile #: (_____)_____

E-Mail Address:_____

Physical Address:_____
Street City State Zip

☐ This individual agrees to provide transportation and shelter for me in the event of an emergency evacuation.

2. Name:_____Relationship:_____
Title First Last

Office Phone #: (_____)_____ext_____ Workplace_____

Home Phone #: (_____)_____ Mobile #: (_____)_____

E-Mail Address:_____

Physical Address:_____
Street City State Zip

☐ This individual agrees to provide transportation and shelter for me in the event of an emergency evacuation.

3. Name:_____Relationship:_____
Title First Last

Office Phone #: (_____)_____ext_____ Workplace_____

Home Phone #: (_____)_____ Mobile #: (_____)_____

E-Mail Address:_____

Physical Address:_____
Street City State Zip

☐ This individual agrees to provide transportation and shelter for me in the event of an emergency evacuation.

4. Name:_____Relationship:_____
Title First Last

Office Phone #: (_____)_____ext_____ Workplace_____

Home Phone #: (_____)_____ Mobile #: (_____)_____

E-Mail Address:_____

Physical Address:_____
Street City State Zip

☐ This individual agrees to provide transportation and shelter for me in the event of an emergency evacuation.

Please feel free to use the end of this packet for additional family members.

DIETARY:

DAILY MENU: Regular:_____Diabetic:_____No Added Salt:_____

(Continue on next page)

Is there some special way we can assist you during the transition to New Cassel or are there any concerns we need to be aware of?

_____

_____

How did you find out about New Cassel? Please check your answer(s)

[ ] Physician [ ] Chapel [ ] Location [ ] Newspaper (OWH or CV)
[ ] Radio [ ] Attorney [ ] Family [ ] TV
[ ] Other:_____

Did you look at other retirement centers? [ ] Yes [ ] No
If yes, which ones?_____

What made you decide that New Cassel was the best choice for you? Please check all that apply:

[ ] Assisted Services [ ] Security [ ] Chapel [ ] Other:_____
[ ] Social Interaction [ ] Location [ ] Environment _____

PLEASE CONTACT ADMINISTRATION AT ANY TIME IF YOU HAVE ANY QUESTIONS OR CONCERNS.