

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.