LAJHealth
LOS ANGELES JEWISH HEALTH

Application for Admission

Please answer all questions completely and accurately.

Applicant's Name _____ Maiden Name _____

_____
Street City Zip Code

Telephone number ( )_____ Cellular number ( )_____

I live at (Check appropriate box)

- ☐ In a rented apartment
- ☐ In my own home
- ☐ In a retirement hotel or board & care facility
- ☐ With one of my children
- ☐ In a nursing home
- ☐ Other _____

How long have you resided at your present address? _____

If less than 2 Years, previous location _____ How long _____

Date of Birth _____ Place of Birth _____
Month/Day/Year City/State/Country

U.S. Citizen ☐ Yes ☐ No Citizenship # _____ Alien Reg # _____

Former Occupation _____

Marital Status (Check One) ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Name of spouse _____

Address of spouse _____

Spouse's former occupation _____

☐ Divorced ☐ Deceased Date _____

Father's Name _____ Birthplace _____

Mother's Maiden Name _____ Birthplace _____

This information is for LAJHealth only and will not be given to any outside organization.

Children and/or Significant Family Members or Friends

Number of Sons _____ Number of Daughters _____

1. _____
Name | Relationship to Applicant | Date of Birth

_____
Home Address | City | Zip Code | Home Phone #

_____
Email Address | Cell Phone #

_____
Occupation | Business Name | Business Address | Business Phone #

_____
Spouse's Name | Spouse's Age | Spouse's Occupation

2. _____
Name | Relationship to Applicant | Date of Birth

_____
Home Address | City | Zip Code | Home Phone #

_____
Email Address | Cell Phone #

_____
Occupation | Business Name | Business Address | Business Phone #

_____
Spouse's Name | Spouse's Age | Spouse's Occupation

3. _____
Name | Relationship to Applicant | Date of Birth

_____
Home Address | City | Zip Code | Home Phone #

_____
Email Address | Cell Phone #

_____
Occupation | Business Name | Business Address | Business Phone #

_____
Spouse's Name | Spouse's Age | Spouse's Occupation

This information is for LAJHealth only and will not be given to any outside organization.

Children and/or Significant Family Members or Friends (continued)

4.

Name _____ Relationship to Applicant _____ Date of Birth _____

Home Address _____ City _____ Zip Code _____ Home Phone # _____

Email Address _____ Cell Phone # _____

Occupation _____ Business Name _____ Business Address _____ Business Phone # _____

Spouse's Name _____ Spouse's Age _____ Spouse's Occupation _____

5.

Name _____ Relationship to Applicant _____ Date of Birth _____

Home Address _____ City _____ Zip Code _____ Home Phone # _____

Email Address _____ Cell Phone # _____

Occupation _____ Business Name _____ Business Address _____ Business Phone # _____

Spouse's Name _____ Spouse's Age _____ Spouse's Occupation _____

6.

Name _____ Relationship to Applicant _____ Date of Birth _____

Home Address _____ City _____ Zip Code _____ Home Phone # _____

Email Address _____ Cell Phone # _____

Occupation _____ Business Name _____ Business Address _____ Business Phone # _____

Spouse's Name _____ Spouse's Age _____ Spouse's Occupation _____

Have you designated a Durable Power of Attorney?

Healthcare ☐ Yes ☐ No Attorney in fact_____Phone #_____

Financial ☐ Yes ☐ No Attorney in fact_____Phone #_____

Do you use a walker? ☐ Yes ☐ No

Do you use a wheelchair? ☐ Yes ☐ No

If yes, is the wheelchair electric? ☐ Yes ☐ No

Are you on a special diet? _____

What are your interests and activities?_____

_____

What organizations or groups are you currently active in? _____

Do you have friends or relatives now living at LAJHealth?

☐ Yes ☐ No Who? _____

Do you have a Health Insurance Policy? ☐ Yes ☐ No

Primary Policy Name _____ Subscriber # _____

Secondary Insurance Policy Name _____ Subscriber # _____

Social Security Number _____

Medicare Number _____

Medi-Cal Number _____

Medicare Part D (Prescription drug plan) _____

Confidential Financial Information

Monthly Income

	Amount	Direct Deposit to Bank
Social Security	_____	☐ Yes ☐ No
Supplemental Government Income	_____	☐ Yes ☐ No
Support from Children	_____	☐ Yes ☐ No
Restitution	_____	☐ Yes ☐ No
Pension	_____	☐ Yes ☐ No
Other	_____	☐ Yes ☐ No

Assets/Net Worth

	Name of Bank	Amount on Last Statement
1. Checking Account	_____	_____
2. Checking Account	_____	_____
3. Savings Account	_____	_____
4. Savings Account	_____	_____

	Description	Estimated Value
Property	_____	_____
Stocks	_____	_____
Bonds	_____	_____
Trusts	_____	_____

Have you given away, transferred or given gifts of any property, money, stocks, bonds or other assets to anyone during the past three years? ☐ Yes ☐ No

Have your funeral and cemetery arrangements been made? ☐ Yes ☐ No

Name of cemetary _____ Paid for ☐ Yes ☐ No

Name of mortuary _____ Paid for ☐ Yes ☐ No

How much is your current montly rent? _____

Please list any debts or monies owed? _____

Credit Card _____
Company's Name Balance Owed

_____ _____
Applicant's Signature Date

_____ _____
Signature of person assisting applicant Date

Person to contact Name _____ Phone # _____

Reason for Applying to LAJHealth at this time

Please write a detailed statement telling us why you would like to come to LAJHealth.

Additional Comments

List of Documents to Submit Prior to Admission

1. Citizenship Papers or a Birth Ceritifcate or Passport

2. Medicare Card and Medicare Part D (Prescription Drug Plan

3. Medi-Cal Card and/or Notice of Action letter

4. Primary or Supplemental Insurance Card (front and back)

5. Mortuary and Burial Contracts

6. Social Security Card

7. Any other legal documents you may possess (i.e., Durable Power of Attorney for Health Care, Durable Power of Attorney for Financial, Family Trust documents, etc.)

***Please Note: Additional documents will be required prior to date of admission.**

1. Original Medi-Cal Card (If applicable)

2. Social Security award letter

3. Three months current bank statements and all other financial documents

Please complete form and mail back to:

LAJHealth
Attn: Admission Department
18855 Victory Blvd
Reseda, CA 91335
Tel:818-774-3308
Fax: 818-774-2446

LAJHealth
LOS ANGELES JEWISH HEALTH

Health History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

_____ ☐M ☐F _____
Name DOB

PERSONAL HEALTH HISTORY

List any medical problems that other doctors have diagnosed:

_____

_____

_____

_____

SURGERIES AND HOSPITALIZATION

Year	Reason	Hospital
_____	_____	_____
_____	_____	_____
_____	_____	_____

HEALTH

Have you resided in another skilled nursing or psychiatric facility? If so, what were the dates and facility names? ☐Yes ☐No

_____

Was was the reason for moving from your facility?

_____

Do you feel you had good care at your current facility? Please explain. ☐Yes ☐No

_____

What are your expectations for care from LAJHealth?