Zen Hospice Project

GUEST HOUSE RESIDENT APPLICATION

APPLICANT INFORMATION

Name: _____ Date of Birth: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Email: _____
Primary Secondary

Sex: M F Ethnicity: Currently residing at home? Y N

Hospice Diagnosis: _____ Secondary Diagnosis: _____

Does Applicant have a Primary Hospice Agency? Y N If Yes, Hospice Name _

Contact Phone: _____ Fax: _____

REFERRAL INFORMATION

Referral Date: _____ Referred By: _____

o Hospice Agency listed above o Hospital o Other: _____

Referring Agency: _____
Phone: Fax:

APPLICANT'S IMPORTANT CONTACTS

Durable Power of Attorney for Healthcare: _____ Relationship: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

Secondary Contact Person: _____ Relationship: _____

Street Address: _____

City/State/Zip: _____

Phone: _____ Email: _____

APPLICANT'S MEDICAL INFORMATION

Primary Physician: _____ Phone: _____

Email: _____ Specialty: _____

Other Medical Provider: _____ Phone: _____

Email _____ Specialty: _____

Is Applicant covered by medical insurance? If Yes, please provide name: _____

For Respite Referrals Only:
Please describe your respite goals. For example: when would you expect to return home?

CURRENT MEDICAL CONDITIONS: (Please Circle all that apply)

SYMPTOMS:

- Difficulty swallowing
- Difficulty breathing
- Nausea/vomiting
- Itching
- Diarrhea
- Other:

MOBILITY:

- Independent
- Assistance Needed
- Wheelchair Needed
- Bed Bound
- Recent Fall
- Other:

PAIN:

- Scale 0-10: _____
- Concerns regarding pain?
- Is pain well managed?

TREATMENT:

- Radiation
- Palliative Chemo
- Wound Care
- Feeding Tube
- Ostomy Care
- Oxygen
- Suction
- Infusions using pumps
- Other:

TOILETING:

- Independent
- Assistance
- Incontinent bladder
- Incontinent bowel
- Foley catheter
- Other:

SPECIAL NEEDS:

- Sight Impaired
- Hearing Impaired
- Adaptive Devices

SMOKER:

- c YES
- c NO

Does Applicant have any special dietary needs or restrictions?

Does Applicant have any Allergies to foods and/or medications? If yes, please describe in full:

Is there any additional information that you would like us to know?

FAMILY INCOME WORKSHEET

Please complete the following information as fully and completely as possible. Copies of current savings, checking, stocks/bond statements are required for financial assessment.

PERSON/PARTY RESPONSIBLE FOR PAYMENTS

TYPE (Check one):

o Self o Money management agency

o Guarantor o Durable Power of Attorney for Finances

o Family member o Other_____

RESPONSIBLE PARTY CONTACT DETAILS:

Name_____Phone _____

Address_____

_____

email _____

MONTHLY INCOME

	Resident:	Family:
Social Security Benefits	$	$
SSDI Security Disability Income	$	$
SSI: Supplemental Security Income	$	$
State Disability benefits	$	$
Private disability	$	$
Retirement/pension	$	$
VA benefit	$	$
Rental income	$	$
Spousal support	$	$
Other:	$	$
TOTAL:		$

MONTHLY ASSETS

	Resident:	Family:
Savings (must attach current statement)	$	$
Checking (must attach current statement)	$	$
Stocks/bonds	$	$
Dividends	$	$
Life insurance	$	$
Real estate	$	$
Other:	$	$
TOTAL:	$	$

RECURRING EXPENSES (Monthly):

Insurance premium	$
Medications	$
Physicians	$
TOTAL:	$

Zen Hospice is not responsible for costs that fall out of the basic range of services we provide to residents.

I CERTIFY THAT THE INFORMATION ABOVE IS COMPLETE AND ACCURATE

X_____X_____X _____

Date Print Name Signature of Applicant/Durable Power of Attorney/Guarantor

Authorization to Obtain Financial Information: (Optional):

I hereby authorize Zen Hospice Project to obtain financial information if I utilize a money management agency or other, in order to determine my room and services fee.

X_____X_____X_____

Date Print Name Signature of Applicant/Durable Power of Attorney/Guarantor

Office use only: UCSF bed: Other: