HCL
WILLIAMS COUNTY
HILLSIDE COUNTRY LIVING

The Heights
The Village
Anna's House
The Heritage

APPLICATION FOR ADMISSION
APPLICATION FOR (Check One)
☐ The Heights (Independent Apartments)
☐ The Village (Assisted Care Apartments)
☐ The Heritage (Nursing Facility)
☐ Anna's House (Memory Impaired Nursing Facility)

PERSONAL INFORMATION
☐ Male    ☐ Female
Full Name (Maiden)
House Number and Street ________________________________
City ___________________________ State ___________ Zip ______
Telephone ___________________________ Referral Source__________
Birth Place City ___________________________ State/County ______
Birth Date (Month/Day/Year) ___________ Present Age ______
Length of Residence in Williams County ___________
Length of Residence in Ohio ___________
Length of Residence in U.S. ___________
☐ Single    ☐ Married    ☐ Widow/Widower    ☐ Divorced    ☐ Companion
Social Security # ________________________
Medicare Number ________________________ Effective Date ______
Medicaid Number ________________________ Effective Date ______
Former Occupation _______________________
Dentist ___________________________ Optometrist ______
Pharmacy ___________________________ 
Drug Plan ___________________________ I.D. # ___________ Group # ______________
Please bring original Social Security, Medicare, insurance cards and either a birth
certificate or driver's license from applicant for verification.

HEALTH INSURANCE SUPPLEMENT POLICY
Insurance Company ________________________________
Contract Number ________________________________
Does applicant have insurance with nursing home coverage? ______
Is applicant or spouse a Veteran? ☐ Yes ☐ No
If yes, please give Veteran's claim number _______________________

LEGAL INFORMATION
Legal Guardian ________________________________
Power of Attorney ________________________________
Durable Power of Attorney (Finances) ________________________________
Durable Power of Attorney (Health Care) ________________________________
Living Will ________________________________
Resident Representative ________________________________
Organ Donor ☐ Yes ☐ No
Please bring applicant's original Power of Attorney, Living Will, Durable Power of Attorney
for Health Care, and Durable Power of Attorney for Finances for verification.
NEAREST LIVING RELATIVE

Please list your nearest living relative, including friends, and all living children. In case of death or serious illness, only one individual will be notified. Attempts will be made beginning with the first person listed below.

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Phone (Daytime/Evening/Cell)</th>
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<tbody>
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MEDICAL HISTORY

Physicians and Specialists Attending

<table>
<thead>
<tr>
<th>Name</th>
<th>Address</th>
<th>Dates of Attendance</th>
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Admitting Diagnosis

General Mental Health

Previous Illness/Hospitalizations – Reasons and Dates

Present Medications

List Available Medical Equipment (check if appropriate)

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<thead>
<tr>
<th>Item</th>
<th>Own</th>
<th>Rent</th>
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<tbody>
<tr>
<td>Cane</td>
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<tr>
<td>Walker</td>
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<tr>
<td>Wheelchair</td>
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<td>Trapeze</td>
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<tr>
<td>Oxygen Concentrator</td>
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<tr>
<td>Catheters</td>
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<tr>
<td>Bariatric Bed</td>
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<td>Other:</td>
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FUNERAL INFORMATION
Has applicant established a burial contract? □ Yes □ No
Please provide the contract for us to copy for our files.

If answer to the above question is no, please list the name and phone number of the funeral home to be notified.
Funeral Home __________________________ Phone Number __________________________

MONTHLY INCOME
Social Security __________________________ Pensions __________________________
Annuities __________________________ Dividends/Interest __________________________
Other Income __________________________
Estimated length of time the applicant will be able to meet all the financial needs.
Months _______/Years ________
We respectfully request to be notified when the applicant’s funds are reduced to three months private pay. If needed, we will assist in applying for Medicaid.

Information contained in this application is accurate and complete to the best of my knowledge.
Applicant’s Signature __________________________ Date __________________________

Legal Guardian/Power of Attorney/Responsible Party
Signature __________________________ Date __________________________

WILLIAMS COUNTY
HILLSIDE COUNTRY LIVING
The Heights | The Village | Anna's House | The Heritage
09876 County Road 16 • Bryan OH 43506 • 419.636.4508

FOR OFFICE USE ONLY
Code Status __________________________ Donor __________________________
Admission Date __________________________ Medical Record Number __________________________
Room Number __________________________ Apartment Number __________________________
Physician __________________________ Transferred From __________________________
Hospital and Physician __________________________
Skilled Letter Sent □ Yes □ No Hospital/Qualifying Dates __________________________
Rehab Dates __________________________