Applicant: This form must be completed by **you** and returned to the Admissions Center as soon as possible.

RCFE Information Form

Applicant's Name ______________________________ Maiden Name ____________________

Address ____
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

Date Arrived In the U.S. ____________ In California ____________ In Los Angeles ____________

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 ____

Date married ______________________________ Place ______________________________

If divorced or if spouse deceased Date ____________________ Place ______________________________

Name of previous spouse ____

☐ Divorced ☐ Deceased Date ____________________ Place ______________________________

Father's Name ______________________________ Birthplace ______________________________

Mother's Maiden Name ______________________________ Birthplace ______________________________

Children and/or Significant Family Members or Friends

Please list relatives, including children, adult grandchildren, nieces, nephews, and first cousins. The information you give is only for LAJHealth and will not be given to any outside organization.

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

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

Person to Contact ____

Name | **Phone #**

Have you designated an Attorney-in-Fact on a
Durable Power of Attorney for Health Care? ☐ Yes ☐ No

Name of Attorney, Trustee or Attorney-in-Fact for Property or Money Management (if any)

____
Name   Address   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? ___________________

What organizations or groups have you been active in? _____________________

Do you have friends or relatives now living at LAJHealth?

☐ Yes ☐ No Who? ______________________________

How were you referred to LAJHealth?_________________________________

Do you have a Medicare Supplemental Health Insurance Policy?

☐ Yes ☐ No Company Name____

Policy # ______________________________ Subscriber # ____________________

Do you belong to a Health Maintenance Organization (HMO)?

☐ Yes ☐ No Company Name____

Policy # ______________________________ Subscriber # ____________________

Social Security Number ________________________________

Medicare Number ___________________________________

SSI/Medi-Cal Number _________________________________

Confidential Financial Information

Monthly Income

	Amount	Direct Deposit to Bank	Account No.
Social Security	________	☐ Yes ☐ No	________
Supplemental Government Income	________	☐ Yes ☐ No	________
Support from Children	________	☐ Yes ☐ No	________
Restitution	________	☐ Yes ☐ No	________
Other	________	☐ Yes ☐ No	________

Pension ______________________________ ________
Company Name Amount

Assets/Net Worth

	Name of Bank & Branch	Account No.	Amount on Last Statement
Checking Account	________	________	________
Savings Account	________	________	________
Savings Account	________	________	________

	Description	Estimated Value
Property	________	________
Stocks	________	________
Bonds	________	________
Trusts	________	________
Automobile	________	________
Life Insurance Policy	________ Company	________ Policy #

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? ______________________

Do you live in HUD Housing? ☐ Yes ☐ No

Please list any debts or monies owed?______________________

Credit Card ______________________
Company's Name Balance Owed

Monthly how much do you spend (Average) ______________________

______________________ ________
Applicant's Signature Date

______________________ ________
Signature of person assisting applicant Date

Reason for Applying to LAJHealth at this time

Please write a fairly detailed statement telling us why you would like to come into 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

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 ?