

## Application for Admission to Grace House Akron

Complete application online or email to [holly.klein@gracehouseakron.org](mailto:holly.klein@gracehouseakron.org)



### Applicants must:

- Be enrolled in a hospice program
- Do not have access to a caregiver or cannot afford a caregiver
- Have a DNR CC order on State of Ohio form
- No symptoms of COVID-19 or exposure to COVID-19 within 48 hours of admission
- Negative TB test or chest x-ray
- Funeral arrangements made or in progress
- Medication and equipment delivery prior to resident arrival

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### Will accept residents with:

- |                                       |   |
|---------------------------------------|---|
| Colostomy                             | Urostomy                                |
| Foley Catheter                        | Denver Drain that hospice staff manages |
| Injections performed by hospice staff | O2 therapy/CPAP/BIPAP                   |
| Wounds with simple dressing changes   |   |

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### Will not accept residents with:

- |                              |                        |
|------------------------------|------------------------|
| Insulin dependent diabetes   | Blood sugar monitoring |
| Residents that wander        | Active TB or COVID-19  |
| MRSA (respiratory)           | Ventilator support     |
| Tracheostomy                 | Tube Feedings          |
| Complicated wounds/dressings |                        |

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**In collaboration with your hospice provider, please complete the following application as thoroughly as possible.**

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Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

SSN: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age: \_\_\_\_\_ Gender: \_\_\_\_\_ Ethnicity: \_\_\_\_\_

Marital Status: \_\_\_\_\_

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**Number of people in immediate household:**

**Living situation immediately prior to Grace House Akron:**

Home     Nursing Home     Family Member Home     Without a home

**Why do you want to live at Grace House Akron?**

**What concerns do you have about your current housing/environment?**

Do you have enough food?  Yes  No    Do you feel safe at home  Yes  No  N/A

**Please list any special care needs, preferences, or allergies:**

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## Diagnosis and Medical History:

What is your primary diagnosis? \_\_\_\_\_

Other medical history: \_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

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Hospice Provider: \_\_\_\_\_

## Caregiver:

Do you have a caregiver now?  Yes  No

If yes, who is your caregiver? \_\_\_\_\_

Caregiver phone: \_\_\_\_\_

## Power of Attorney:

Do you have a Health Care P.O.A?  Yes  No

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have a Living Will?  Yes  No

Do you have a DNR?  Yes  No

## Do you have a legal Guardian?

If yes, who is your Guardian? \_\_\_\_\_

Guardian phone: \_\_\_\_\_

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## Financial Information

Occupation: \_\_\_\_\_ Retired: \_\_\_\_\_

Employer: \_\_\_\_\_

Household Income (Total monthly income): \_\_\_\_\_

Total monthly expenses: \_\_\_\_\_

Income Sources: \_\_\_ Employment \_\_\_ Retirement/Pension \_\_\_ Social Security \_\_\_ Disability  
\_\_\_ Other

Savings account  Yes  No If yes, current balance: \$ \_\_\_\_\_

IRA, 401k, Investments  Yes  No If yes, current balance:  
\$ \_\_\_\_\_

Stocks, Bonds  Yes  No If yes, current balance: \$ \_\_\_\_\_

Checking Account  Yes  No If yes, current balance: \$ \_\_\_\_\_

Do you own home/property?  Yes  No If yes, value: \$ \_\_\_\_\_

Mortgage balance: \$ \_\_\_\_\_ 2<sup>nd</sup> mortgage balance if applicable \$ \_\_\_\_\_

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## Emergency Contact Information:

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

Shoe size: \_\_\_\_\_ Pant/shirt size (S, M, L, etc): \_\_\_\_\_

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## Do you own a pet:

- If yes, please tell us about your pet(s)

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Is there anything else we should know about you?

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## Funeral Home

Name of Funeral Home: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: \_\_\_\_\_

Have funeral arrangements been finalized?  Yes  No

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**Consent to release information:** I authorize the exchange of information between my physician, hospice agency, caregivers, and Grace House Akron, to coordinate care at Grace House Akron.

**Signature of Applicant:** \_\_\_\_\_

**Signature of person signing for applicant:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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## Office Use Only

Approved By: \_\_\_\_\_ Date: \_\_\_\_\_

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