Henderson County Retirement Center, Inc.
Oak Lane Nursing & Rehab
604 Oakwood Drive
Stronghurst IL 61480

Resident Identification

Residents Name________________________________ Nickname ___________________________________

Address____ Phone________-_______-________

City, State, Zip Code____ County: ________________

Registered Voter   Yes or No

Prior Living Arrangements:

Alone______With Family________Other Facility: ______________________________

Sex: Male   or   Female   Birth date_________________Birthplace__________________

Social Security Number: _______________________

Medicare Number: ___________________________

Medicaid Number: ___________________________

Marital Status

Never married   Married   Widowed   Separated   Divorced

Is spouse living?   Yes   or   No   Number of Children: ___________

Spouse Name__________________________ Phone Number________________________

Address____

City, State, Zip_________________________________ Occupation______________________

Military

Military Service   Yes or No   Branch of Armed Forces_____________________________

Advanced Directives

Power of Attorney for Health Care: Yes or No Agents Name___________________________

Power of Attorney for Finances: Yes or No Agents Name___________________________

Living Will: Yes or No

Physicians

Name of Medical Doctor ____ Phone #______________________

Name of Alternate Doctor ____Phone #: _______________________

Name of Psychiatrist Doctor ____ Phone #_____________________

Name of Foot Doctor ____ Phone #_______________________

Name of Eye Doctor ____ Phone #_______________________

Immunizations Records Yes or No Can you obtain a copy for Oak Lane?

Preferred Religion

Congregation____ Clergy_______________________________

Address ____Phone Number___________________________________

City,State, Zip Code____

Professional Services

Funeral Home____

Address ____Phone Number______________________

City,State,ZipCode____

Educational and Occupational History

Education Level_______________________________________ Primary Language____________________________

Previous Occupation______________________________ Date of Age of Retirement________________________

Hobbies Special Interests:

Contact Information

Please list contact person(s). These Names will be listed on the face sheet in chart as person(s) to be contacted for needs or emergencies.

Name_______________________________________ Relationship ___________________________________

Address_______________________________________City, State,Zip___________________________________

Phone Number________________________________ Work Phone_______________________________________

***Name listed #1 space will be considered first Emergency Notification.

Name_______________________________________ Relationship ___________________________________

Address__________________________________City, State,Zip____

Phone Number________________________________ Work Phone_______________________________________

Name_______________________________________ Relationship ___________________________________

Address__________________________________City, State,Zip____

Phone Number________________________________ Work Phone_______________________________________

Name_______________________________________ Relationship ___________________________________

Address__________________________________City, State,Zip____

Phone Number________________________________ Work Phone_______________________________________

Billing Information (Responsible Party)

Bills sent to ____

Name

____

Address

Phone Number______________________________________

Criminal Background Checks

Have you ever had any dealings with the court system?   Yes or No

Have you ever been convicted of a sex crime? Yes or No

Explain: ____

As required by the State of Illinois, based on the Illinois Department of Public Health Emergency Rules: Background checks must be completed on every potential nursing home resident prior to admission. ***Oak Lanes policy is that we do not accept any type of offender effective October 2022.

Consent for a background check

Do you authorize Oak Lane Nursing & Rehab to run a criminal background Check on

____________________________?
Name

Resident or Responsible party Signature: ____________________________________

Mental Illness

Do you/or your loved one have any mild to moderated mental illness? If so, what is the diagnosis? Are there any symptoms or specific behaviors we should monitor or be aware of?

____

Oak Lane Nursing & Rehab does not have the services and/or the staff to offer treatment for persons with severe mental illness; therefore, Oak Lane cannot admit persons who require special treatment of these disorders.

If after being admitted into Oak Lane, should you suffer severe mental ailments making it expedient to terminate your stay here; do you agree to be transferred to some other suitable institution?
Yes or No

Signature of Applicant _______________________________________ Date________________

Witness Signature ____ Date________________

*** Completing this application doesn't mean the facility has accepted you/or your loved one. This is a pre-requirement during the referral process.

HENDERSON COUNTY
RETIREMENT CENTER, INC.

OAK LANE NURSING & REHAB
PO Box 30 ○ Stronghurst, IL 61480
(309)924-1123

OAK WOOD ESTATES
200 S Logan ○ Stronghurst, IL 61480
(309)924-1910

APPLICATION FOR ADMISSION

Please give ALL information requested on pages 1 - 3: **Date ____ / ____ / ____**
(Please notate "N/A" for "Not Applicable" where appropriate)

Name of Applicant____
Last First Middle

Is placement considered Short term ____ or Long term ____ (check one)

I am looking for immediate placement: ☐ Yes ☐ No

I am hoping for admission with the next 1-6 months: ☐ Yes ☐ No

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Home Address ______________________________ Telephone No. ______________
Street

____
City State County Zip Code

Birth Date ________________ Age __________ Sex ________Citizenship____________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Name of Spouse ____

Present Location of Applicant (if other than home address):______________________

Address:____
Street City State Zip Code

Former Residence in a Nursing Home or Adult Care Facility?: ☐ Yes ☐ No If so, where__________

Do Not Resuscitate Order: ☐ Yes ☐ No Organ Donation: ☐Yes ☐ No

Does Applicant have wandering ☐ Yes ☐ No or aggressive behaviors ☐ Yes ☐ No?

- Please explain ____

Social Security No. ________________ Veteran: ☐ Yes ☐ No Spouse Veteran: ☐ Yes ☐ No

Medicare No. ________________ ☐ Part A ☐ Part B Effective Date ______________

Medicare D Prescription Plan No. ______________________________________

Medicaid RIN No. ______________________________ County

____

Effective Date ________________ Pending Application/Date Submitted ________________

Medicare Supplement Insurance Name and No. (Or other secondary insurance) ______________

____

Insurance Prescription Card No. ______________________________________

Long Term Care Insurance Name and No. ________________________________

Other Insurance ____

Attending Physician ______________________________ Telephone No.______________

Address ____
Street City State Zip Code

(Please submit copies of all insurance cards with application)

Funeral Home____

Name Address Phone #

Life Insurance____

Company Name Policy #

Face Value Amount_____________________ Cash Value Amount _____________________

Beneficiary____

Name Address Phone #

Responsible Party:

Name_____________________ Relationship_____________________ Telephone No._____________________

Address ____

Street City State Zip Code

Power of Attorney/Guardian(s)/Conservators

(Attach copies of Power of Attorney, Guardianship and Conservator Court Orders)

Name ____ Telephone No._______________

Address ____

Street City State Zip Code

Health Care Power of Attorney/Guardian(s)/Conservators

(Attach copies of Power of Attorney, Guardianship and Conservator Court Orders)

Name ____ Telephone No._______________

Address ____

Street City State Zip Code

Applicant's Monthly Income:

Salary..$_________________/month

Social Security...$_________________/month

Retirement Pension Name (Please Specify): ____________________$_________________/month

Veteran's Pension...$_________________/month

Railroad Pension..$_________________/month

Supplementary Security Income:................................$_________________/month

Other Monthly Income (Please Specify):________________________$_________________/month

Applicant's Spouse's Monthly Income:

Salary..$_________________/month

Social Security...$_________________/month

Retirement Pension Name (Please Specify): ____________________$_________________/month

Veteran's Pension...$_________________/month

Railroad Pension..$_________________/month

Supplementary Security Income:................................$_________________/month

Other Monthly Income (Please Specify):________________________$_________________/month

Assets of Applicant and Applicant's Spouse:

Name of Investment/Broker Accts ______________________ Present Value ____________

Address of Investment/Broker Accts ______________________

Checking Account: Bank ____________ Account No. __________ Amount __________

Bank ____________ Account No. __________ Amount __________

Savings Account: Bank ____________ Account No. __________ Amount __________

Bank ____________ Account No. __________ Amount __________

Real Estate: ☐ Yes ☐ No

Name/Address of Trusts ______________________ Date Trust Establish __________

Beneficiaries ______________________ Amount __________

Other Assets ______________________

Liabilities of Applicant and Applicant's Spouse:

Mortgage...$____________/month

Credit Card Institution(s) ______________________ Account No(s). __________

Other (Please Specify): ______________________$____________/month

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BY SIGNING THIS APPLICATION, I AUTHORIZE THE FACILITY TO VERIFY WITH BANKS, EMPLOYERS, VETERAN'S ADMINISTRATION, SOCIAL SECURITY, MEDICAID, INSURANCE AND/OR OTHER INSTITUTIONS ACCURACY OF INFORMATION

To the best of my knowledge all the above information is correct and valid.

______________________________ ______________

Signature of Applicant or Responsible Party ***(REQUIRED)*** Date

Applications are accepted and considered without regard to race, creed, color, age, sex, religion, national origin, sponsor, sexual preference, blindness, or other handicap.