*Customary Routine during the last year:*
(check all statements that apply)

**CYCLE OF DAILY EVENTS:**
- ☐Stays up later than 9pm
- ☐Naps regularly for more than one hour
- ☐Goes out more than once per week
- ☐Stays busy with hobbies, reading or daily routine
- ☐Spends most time alone or watching TV
- ☐Moves independently indoors (with adaptive device if used)
- ☐Use of tobacco daily
- ☐None of the above

**ACTIVITIES OF DAILY LIVING PATTERNS:**
- ☐In bedclothes most of the day
- ☐Wakens to toilet most or all nights
- ☐Has irregular bowel movement patterns
- ☐Showers for bathing
- ☐Bathing in P.M.
- ☐None of the above

**EATING PATTERNS:**
- ☐Distinct food preferences
- ☐Eats between meals all or most days
- ☐Any ethnic/religious food preferences
- ☐None of the above

**INVOLVEMENT PATTERNS:**
- ☐Daily contact with relatives or friends
- ☐Usually attends religious services
- ☐Finds strength in faith
- ☐Daily animal companionship or presence
- ☐Involved in group activities
- ☐None of the above

**FAMILY PERSPECTIVE OF PATIENT CARE NEEDS:**

1. Describe the patient's overall condition and mental status, including their medical needs as you understand them:

2. What are your ***goals*** for the patient during the stay at Woodbine?

3. What are your overall ***expectations*** of the time spent at Woodbine?

__________________________ __________________ ____________
Signature of person completing form    Patient Name    Date

2729 King Street    Alexandria, VA 22302    703-836-8838    Fax 703-836-2965    www.woodbinerehab.com

Patient Name: ____________________________________

Date of Birth: _____-_____-_____    Social Security #: _____-_____-_____

Address: __________________ City: _________ State: ____ Zip: ______

Home #: ____________ Work #: ____________ Cell #: ____________

Gender: ☐Male ☐Female    Legal Marital Status: ☐Married ☐Single ☐Separated ☐Divorced ☐Widowed

Birthplace: __________ Religion: __________ Race: __________

US Citizen? ☐Yes ☐No; does patient have Green Card? ☐Yes (must provide copy) ☐No

Primary Language: ☐English ☐Spanish ☐French ☐Other________

Education: ☐Unknown ☐None ☐8th Grade or less ☐9-11th Grade ☐High School ☐Tech/Trade School ☐Some College ☐Bachelor's Degree ☐ Graduate Degree

Occupation: __________________    Does patient live alone? ☐Yes ☐No

Has patient ever been admitted to Nursing/Rehabilitation Facility? ☐Yes ☐No
If yes, name facility and dates of stay: ________________________

How were you referred to Woodbine? ☐Hospital ☐Physician ☐Social Work ☐Advertising

Patient is currently at: ☐Home ☐Hospital ☐Assisted Living ☐Adult Home ☐Other

**Responsible Party/Emergency Contact:**

Name: ____________________________________

Address: ____________________________ State: ____ Zip: ______

Home#: ____________ Work #: ____________ Cell #: ____________

Relationship to patient: ☐ POA ☐Guardian ☐Spouse ☐Son ☐Daughter ☐Other______
(Must provide copies of POA or Guardianship)

2nd Emergency Contact: ____________________ Relationship: ________

Home #: ____________ Work #: ____________ Cell #: ____________

3rd Emergency Contact: ____________________ Relationship: ________

Home #: ____________ Work #: ____________ Cell #: ____________

Does patient have Advanced Directive? ☐Yes (must provide copy) ☐No

**Primary Admission Payment Source:** ☐Medicare ☐Private Insurance ☐Self Pay ☐Medicaid

## INSURANCE COVERAGE

* a copy of all Insurance Cards must be provided in order for Woodbine to bill insurance

### Medicare

Policy #: ______________________________________

Part A: ☐No ☐Yes; effective date: ____________
Part B: ☐No ☐Yes; effective date: ____________
Part D: ☐No ☐Yes; effective date: ____________ Name of plan: _____________

Is patient or spouse of patient currently employed? ☐Yes ☐No; Date of retirement: ______
Is Medicare patient's primary payer? ☐Yes ☐No

### Private Insurance

Company: __________________ Policy #: __________________ effective date: _________

Name of policy holder: ___________________________

Company: __________________ Policy #: __________________ effective date: _________

Name of policy holder: ___________________________

### Medicaid

☐Virginia ☐DC ☐other __________

Policy #: ______________________ County issued: _______________ Date issued: _____

What will your "patient pay" be at Woodbine? $__________ Eligibility Worker: __________

If patient does not currently have Medicaid, will he/she be eligible in 6 months? ☐Yes ☐No

Has a Medicaid application been submitted or started? ☐Yes ☐No

Has a Medicaid application been made for this patient within the past 2 years? ☐Yes ☐No

Has the patient ever been rejected for Medicaid?
☐No ☐Yes; explain: ________________________________________________

Was an appeal filed? ☐No ☐Yes; date: __________________

### POST-INSURANCE INFORMATION

1) How long does the patient plan to reside at Woodbine? ☐Short-term ☐Long-term

2) Is the patient able to handle his/her own affairs? ☐Yes ☐No

3) Name of person who will be financially responsible for patient's cost of care:

Name: _____________________________________ Relationship: ____________________

Address: __________________________________________State: ________ Zip: _______

Phone: ___________________________

## FINANCIAL ASSISTANCE SCREEN

1. Does the patient own real estate or a home? ☐No ☐Yes

   If yes; Location: __________________ Est. Market Value: _______________

2. Checking Account:
   Financial Institution: __________________________ Est. Balance: $__________
   Financial Institution: __________________________ Est. Balance: $__________

3. Savings Account:
   Financial Institution: __________________________ Est. Balance: $__________
   Financial Institution: __________________________ Est. Balance: $__________

4. Stocks, Securities, Bonds:
   Financial Institution: __________________________ Est. Value: $__________
   Financial Institution: __________________________ Est. Value: $__________

5. Social Security Monthly Income: $______________

6. Pension/IRA/401K/Annuities:
   Financial Institution: __________________________ Est. Income: $__________
   Financial Institution: __________________________ Est. Income: $__________

7. Insurance Policies:
   Company: _________________ Beneficiary: _______________ Est. $: _________
   Company: _________________ Beneficiary: _______________ Est. $: _________

8. List other assets not listed above: ____________________________________________
   _______________________________________________________________________________

9. Debts:
   a. Notes due: ________________________________________________________
   b. Accounts due: _____________________________________________________
   c. Loans: ___________________________________________________________

10. Has the patient transferred any assets over $5,000 in value (including real estate, stocks or Bonds to another person without consideration? ☐Yes ☐No

    if Yes, explain: _____________________________________________________
    ______________________________________________________________________

    if Yes, did the transfer occur within the last 60 months? ☐Yes ☐No

11. Patient has greater than six (6) months worth of assets to cover cost of care at Woodbine: ☐Yes ☐No

__________________________________________ ____________________
Signature of person completing "Insurance Coverage" and "Financial Assistance Screen" Date

__________________________________ ______________________________
Print Name Patient Name