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