

APPLICATION FOR ADMISSION

Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Telephone Number _____ Social Security Number _____

Sex: male _____ female _____

Marital Status: single _____ married _____ widowed _____ divorced _____

Birth date _____ Place of birth _____

Mother's maiden name _____ Father's name _____

Person to contact in case of necessity (next of kin):

Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Telephone Number _____ Relationship _____

Business Telephone Number _____ Cell Phone Number _____

Durable Power of Attorney for Health Care

Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Telephone Number _____ Relationship _____

Business Telephone Number _____ Cell Phone Number _____

Person who can act legally for you if necessary:

Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Telephone Number _____ Relationship _____

Business Telephone Number _____ Cell Phone number _____

Person authorized to pay bills (if a different person than listed above):

Name _____

Address _____

City _____ State _____ Zip _____

Email _____

Telephone Number _____ Relationship _____

Business Telephone Number _____ Cell Phone Number _____

Is applicant requesting financial assistance? _____ If yes, please apply online to the National Fund for Christian Science Nursing. Information is included in packet.

Do you have insurance? Yes _____ No _____ If yes, with whom? _____

How long has applicant relied on Christian Science for healing? _____

Is applicant a member of The Mother Church? _____

Is applicant a member of a branch church? _____ If yes, which branch? _____

Has the applicant had Christian Science Class Instruction? _____

Name of teacher _____

Does applicant use the Bible and *Science and Health with Key to the Scriptures* by Mary Baker Eddy as his/her only textbooks in the study of Christian Science? _____

Does applicant use? tobacco _____ alcoholic beverages _____ drugs _____ medication _____
any medical devices _____

Are members of the applicant's immediate family students of Christian Science? _____

Are they supportive of the applicant's desire to come to Glenmont? _____

Does the applicant have a home to return to? _____

If not, what arrangements will be made? _____

Please give a personal reference, other than a relative, preferably a member of The Mother Church:

Name _____

Address _____

City, State and Zip _____

Home Telephone Number _____ Office Telephone Number _____

Email _____

Please give the name of applicant's *Christian Science Journal*-listed practitioner:

Name _____

City and State of *Journal* listing _____

Home Telephone number _____ Office Telephone Number _____

Has the practitioner agreed to remain on the case if applicant is admitted to Glenmont? _____

When was the last time the practitioner visited the applicant? _____

In the event that applicant's practitioner is unavailable, please list a second *Journal*-listed practitioner:

Name _____

City and State of *Journal* listing _____

Home Telephone number _____ Office Telephone Number _____

Have you received any medical treatment within the last five years? _____ If yes, please give details including institution names and specific dates. _____

Have you ever stayed at a Christian Science nursing facility? _____ If yes, please give details including institution names and specific dates. _____

To assist the Christian Science Nursing Department determine the need for nursing care, please state why the applicant is applying to Glenmont and what nursing services the applicant requires. _____

Please check all items appropriate to the applicant's current need.

_____ Needs assistance when walking

_____ Uses walker

_____ Uses cane

_____ Uses wheel chair

_____ Needs assistance in & out of bed

_____ Needs to be lifted from chair to bed

_____ Needs complete care in bed

_____ Needs help to change position in bed

_____ Wears hearing aid

_____ Wears glasses

_____ Needs to be read to

_____ Needs assistance to wash & dress

_____ Needs assistance to bathroom

_____ Needs all personal care to be given by Christian Science Nurse

_____ Needs assistance with weekly bath

_____ Needs assistance with meals

_____ Needs to be fed

_____ Needs food to be blended

_____ Needs reassurance

_____ Needs encouragement

_____ Needs frequent reminders

Please list any area(s) requiring special cleansing or any area(s) needing to be covered or bandaged: _____

Any other information we need to know in order to provide proper care:

THE APPLICANT UNDERSTANDS AND ACKNOWLEDGES THE FOLLOWING:

- While personal preferences will be considered, care may be rendered by a male or female Christian Science Nurse.
- Applicant will not receive medication of any type and that no material remedies are used at Glenmont.
- That no liquor, tobacco, drugs or caffeinated beverages are available or to be used at Glenmont.
- That, per Ohio law, a criminal background check and sexual offender check will be made on the Applicant.
- That while a patient at Glenmont, applicant will receive daily treatment from a Christian Science Practitioner of his/her choice listed in the current issue of *The Christian Science Journal*.
- The Christian Science Nursing staff of Glenmont has the authority to call a *Journal*-listed practitioner in the event the applicant's regular practitioner cannot be reached. Glenmont is not responsible for payment for any practitioner contacted for the patient.
- Glenmont is not responsible for personal property or valuables.
- Applicant will cheerfully change rooms if so requested.
- Glenmont reserves the right, upon thirty days' notice, to transfer or discharge the applicant from Glenmont if, in the judgment of Glenmont's senior Christian Science nursing staff, the applicant ceases to rely solely, radically, and actively on Christian Science for healing. The applicant may also be transferred or discharged, upon thirty days' notice, if the applicant ceases to pay his/her bills or if the Administrator deems such actions to be for the welfare of the applicant or of other patients. The applicant or sponsor may discharge the applicant from Glenmont at any time, thereby releasing Glenmont of all responsibility and legal liability as a result of or in connection with his/her leaving.
- I have read a copy of the room rates and will provide for prompt payment of bills when presented, including charges for additional items, such as hairdresser bills, supplies, etc. Glenmont bills at the beginning of each month and will give a 30 day notice of rate change.
- All of the above statements are true to the best of my knowledge. I understand that I may be asked to leave Glenmont if these statements are found to be false or misrepresented.