



RESIDENT APPLICATION
**** PLEASE COMPLETE PRIOR TO ADMISSION ****

Resident Name: Carol Diane Gray ("Diane")

1. Resident admitted to Valley Hi from? resides with boyfriend/caregiver

2. Please list all hospital stays during the past 90 days: N/A

Date Admitted _____ Hospital Name _____

Date Discharged _____

Date Admitted _____ Hospital Name _____

Date Discharged _____

Date Admitted _____ Hospital Name _____

Date Discharged _____

3. Please list all skilled nursing facility stays during the past 90 days: N/A

Date Admitted _____ SNF Name _____

Date Discharged _____

Date Admitted _____ SNF Name _____

Date Discharged _____

4. Does resident have a primary or supplemental insurance HMO plan? If yes, we must have a copy of the insurance card in order to contact the HMO plan prior to admission.

Yes

(No)



Signature

C. D. Gray

Date

9/28/25

VALLEY III NURSING & REHABILITATION

Name Last, First, Middle Initial Gray, Carol D.		Admitted From N/A		Resident Address (Street, City, State, Zip Code, County) 26131 W. Elm Tree Rd. Antioch, IL 60002			Phone Number 847-800-8450	
Social Security Number 281-50-6247	Birth Date 8/2/62	Age 62	Birthplace (City/State/County) Columbus, OH		Religion Catholic	Language English	Sex F	Marital Status D
US Veteran/Branch N/A	Citizen USA	Race Caucasian	Medicaid ID Number 326238797		Medicaid Case Number			
Medicare Number N/A		Medicare Rx (Part D)/Other Pharmacy N/A			Supplemental Insurance Name/Number N/A			
Primary Care Physician/Phone Number All Time Urgent + Medical 847-367-6400		Dentist/Phone Number Heritage Dental 847-395-1461			Eye Doctor/Phone Number America's Best 815-528-1031			
Funeral Home				Church (occasional) Our Lady of the Lakes / St. Peter				
Power of Attorney/Guardian – Healthcare N/A				Power of Attorney/Guardian – Property (Financial) N/A				
Notify in case of Emergency #1 Name/Address Robert Dunlap 26131 W. Elm Tree Rd Antioch, IL 60002				Home Phone Number: 847-395-4155 Work Number: Cell/Pager Number: 847-254-1136		Relationship friend, caregiver		
Notify in case of Emergency #2 Name/Address Megan Lauderdale 454 South Maple St Itasca, IL 60143				Home Phone Number: Work Number: Cell/Pager Number: 312-767-6040		Relationship daughter		
Notify in case of Emergency #3 Name/Address Jon Gray 14717 245th Ave SE Issaquah, WA 98027				Home Phone Number: Work Number: Cell/Pager Number: 206-485-5324		Relationship son		

Consulting Physicians: (Cardiologist, Orthopedics, Psychiatrist, Neurologist, Nephrologist, Dermatologist, etc.)

Name	Specialty	Phone Number
Paul L. Grindstaff, MD	Neurologist	815-455-1800
Melissa A. Lancaster	Neuropsychologist	630-933-4056
Zoran M. Grujic, MD	Behavioral Neurologist	630-933-4056
Dr. W. Widmeyer	Neurologist	847-570-2570 847-663-8200

Present Condition: (Check all that apply)

~~***~~ only used on longer walks as an emergency seat/transport

Ambulation

Independent

~~***~~ Wheelchair

Cane/Walker

Bedridden

~~X~~ Assistance Required

~~X~~ One Person

Two Person

Electric Wheelchair

Impairment

~~X~~ Vision

Hearing

Speech

~~X~~ Incontinence

Contractures

Paralysis

Needs assistance to get to toilet and sit ... and then to wipe clean and wash hands

Can stand and slowly walk, but unsteady and does not know where to walk

Mental Status/Temperament

~~X~~ Sociable, but mostly

Timid

Independent

Prefers being alone

~~X~~ Prefers groups

Mentally alert

~~X~~ Confused

~~X~~ Grouchy

~~X~~ Suspicious

~~X~~ Withdrawn

~~X~~ Depressed

~~X~~ Forgetful

~~X~~ Cries easily

Special Precautions

Combative

Chokes Easily

Hides Pills

Suicidal

Wanders/Exit Seeking

Hallucinates

Anxious

Physically aggressive

Other

Applicant Has

Dentures

~~X~~ Eyeglasses

Hearing Aid

Prosthesis

Braces/Splints

At times ... evenings mostly, may happen a few days in a row and then not so much for many days.

Self-care Capability	Independent	Needs Assistance	Unable	Resistive	Combative
Washing face and hands		X			
Bathing/Showering		X			
Getting in and out of bed	Out X	X in X			
Caring for hair		X			
Caring for fingernails and toenails		X	X		
Shaving			X		
Brushing teeth		X → put paste on brush			
Toileting		X			
Dressing or undressing			X		
Feeding		X			

Medications: Please list all current medications (prescription, over-the-counter and herbal).

Drug	Dosage	Frequency	Drug	Dosage	Frequency
Donepezil	10 mg	1/d	alpha lipoic acid	600 mg	1/d
Sertraline	50 mg	1/d	divalproex	250 mg	1/d
Amlodipine	10 mg	1/d	Vitamin B complex Oral		1/d
Memantine	10 mg	2/d	Brain boosting focus + memory	↓	3/d
			- citicoline sodium	250 mg	
			- coffee fruit extract	100 mg	
			H-D-3-K2	↓	1/d
			- vitamin A	5,000 IU	
			- vitamin D3	5,000 IU	
			- vitamin K2	90 mcg	

100 mg thiamine B1
100 mg B-2
100 mg B-3
100 mg B-6
680 mcg DFE
100 mcg B-12
100 mcg biotin
100 mg panto-
thenic acid
40 mg choline
100 mg PABA
100 mg inositol

ASSETS:	RESIDENT
Cash	\$ 100
Checking	\$ 900
Savings	\$ 0
Money-Market	\$ 0
Certificate of Deposit (CD)	\$ 0
Securities (Stock /Bonds)	\$ 0
Trusts	\$ 0
Annuities	\$ 0
IRA's	\$ 0
MONTHLY INCOME:	
Social Security	\$ 1,200 (disability)
Pension/Annuities	\$ 0
IRA's	\$ 0
Interest/Dividend Income	\$ 0
Rental Income	\$ 0
Trust	\$ 0
Investments	\$ 0
REAL ESTATE:	
Property Address:	none
(Name on Deed/Title)	
Property Address:	none
(Name on Deed/Title)	
OTHER ASSETS:	
Cash Value Life Insurance	none
Vested Pension Benefits	none
Business Interests	none
Automobiles	2014 Nissan Juke
Other Assets	just personal belongings (clothes)
LIABILITIES:	
Home Mortgage	\$ n/a
Credit Cards	\$ -2,968.91 (amt. owed)
Loans	\$ n/a
Taxes Owed	\$ n/a
Other Debts	\$ n/a

PLEASE SIGN BELOW:

I hereby warrant and represent that the financial information provided above is accurate and complete. I understand that Valley Hi will rely upon it in making an admission decision. The assets listed are in fact available to the Resident to pay for the Resident's care.

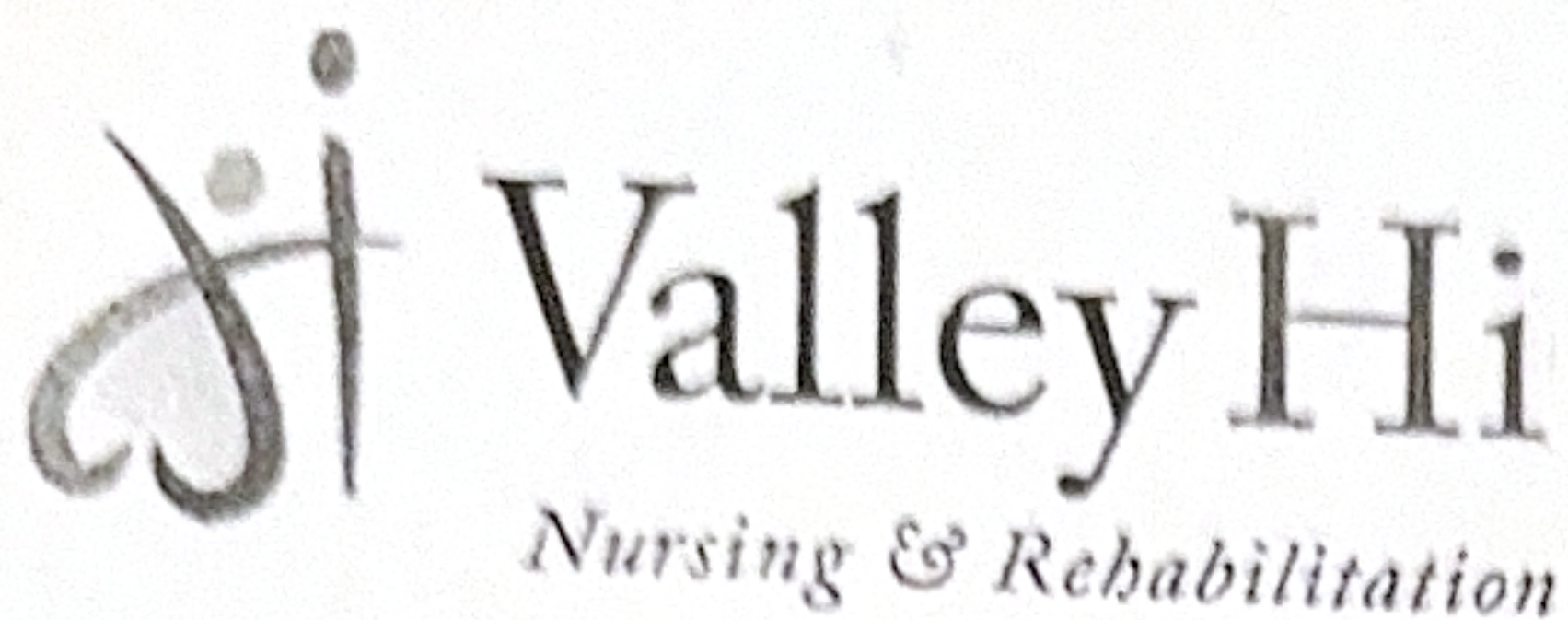
*

C.D. [Signature]

Resident's or Responsible Party's Signature

9/28/25

Date



AUTHORIZATION for RELEASE of INFORMATION

1. Carol Diane Gray
(Patient/Resident Name)

8/2/1962

(Patient/Resident Birth date)

1. _____
(The Responsible Party)

OR
for

(Patient/Resident Name)

Authorize Northwestern ER, NW Wound Care, All Time Urgent + Medical, Endeavor
(Name of facility from whom information is requested) Health Medical Group

to release the following information from my medical records:

☒ MAR

☒ Lab Reports

☒ MEDS

☒ Therapy Notes

☒ History & Physical

☒ Physician Orders

☒ Last Date of Flu & Pneumonia Vaccine

OTHER: _____

☒ Last Date & Results of TB/Mantoux Vaccine

To be sent to: **VALLEY HI NURSING & REHABILITATION**
(Name of Facility)

2406 HARTLAND RD. WOODSTOCK IL 60098
(Address of facility)

815-338-0458
(Fax number)

For the limited purpose of: Evaluation & Treatment

Information released is not to be further disclosed or used for any purpose other than that stated in this authorization. It is understood that I have the right to revoke this consent in writing at any time. Any revocation shall be in writing, signed by me and the signature witnessed by a person who can attest to my identity. No written revocation of consent shall be effective until it is received by the person otherwise authorized to disclose records and shall have no effect on disclosures made prior thereto. I understand that I have the right to inspect and copy the information released. I further understand that my refusal to consent to the release of information specified will prevent disclosure of such information to the facility or person named herein for the stated purpose.

This authorization is valid until: 9/28/27
(2 years from today's date)

*

C. D. Gray
(Patient/Resident or Responsible Party Signature)

Date: 9/28/25

Ellen Harris (sister)
(Witness signature & Relationship to Patient)

Date: 9/28/25

2406 Hartland Rd + Woodstock, IL 60098 +



+ 815-338-0312 + www.co.mchenry.il.us