# Anmeldung für einen Temporär-/Langzeitaufenthalt

**Pflege & Betreuung oder Wohnungen**

Stand 02.2020

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Pflegebereich | | | | | | | | | | | |  | | | Wohnung | | | | | | |
|  | Einerzimmer in Wohngruppe | | | | | | | | | | |  | | |  | 1 ½ Zimmer | | | | | |
|  | Einerzimmer | | | | | |  | | | | |  | | |  | 2 Zimmer | | | | | |
|  | Zweierzimmer | | | | | |  | | | | |  | | |  | 2 ½ Zimmer | | | | | |
|  | Gastzimmer ohne Inhouse-Spitex | | | | | | | | | | |  | | |  | 3 ½ Zimmer | | | | | |
|  | Gastzimmer mit Inhouse-Spitex | | | | | | | | | | |  | | |  | Garagenplatz | | | | | |
| Gewünschter Eintritt | | | | | | | | | | | | | | | | | | | | | |
|  | | Dringlich | | | | bis | Innerhalb 12 Monaten | | | | | | | |  | | Vorsorglich | | | | |
| Bemerkung: | | |  | | | | | | | | | | | | | | | | | | |
|  | | |  | | | | | | | | | | | | | | | | | | |
| **Personalien und allgemeine Angaben** | | | | | | | | | | | | | | | | | | | | | |
| Name und lediger Name | | | | | | | |  | | | | | | | | | | | | | |
| Vorname | | | |  | | | | | | | Strasse | | | | | | |  | | | |
| Wohnort | | | |  | | | | | | | Kanton | | | | | | |  | | | |
| Tel. Privat | | | |  | | | | | | | Tel. Mobil | | | | | | |  | | | |
| E-Mail | | | |  | | | | | | | Konfession | | | | | | |  | | | |
| Heimatort | | | |  | | | | | | | Muttersprache | | | | | | |  | | | |
| Geb. - Datum | | | |  | | | | | | | Soz. Vers.**1)** | | | | | | | **756 …** | | | |
| Zivilstand | | | |  | | | | | | | Ehem. Beruf | | | | | | |  | | | |
| **Gegenwärtiger Aufenthalt** | | | | | | | | | | | | | | | | | | |  | | |
|  | | Institution (Spital, Klinik etc.) | | | | | | |  | | | | | | | | | | | | |
|  | | Privathaushalt | | | | |  | |  | | | | | | | | | | | | |
| Es besteht eine Beistandschaft | | | | | | | | | nein | ja | | | |  | | | | | | | |
| **Kontaktperson** | | | | | | | | | | | | | | | | | | | | | |
| Name | | | | |  | | | | | | | | Vorname | | | | | | |  | |
| Strasse | | | | |  | | | | | | | | PLZ, Wohnort | | | | | | |  | |
| Tel. Privat | | | | |  | | | | | | | | Tel. Mobil | | | | | | |  | |
| Tel. Gesch. | | | | |  | | | | | | | | Verwandtschaftsgrad | | | | | | | |  |
| E-Mail | | | | |  | | | | | | | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Ergänzende Informationen** | | | | | |
|  | | | | | |
|  | | | | | |
|  | | | | | |
|  | | | | | |
| Weitere Bezugspersonen | |  | | |
| Name |  | Vorname |  | |
| Strasse |  | PLZ, Wohnort |  | |
| Tel. Privat |  | Tel. Mobil |  | |
| Tel. Gesch. |  | Verwandtschaftsgrad | |  |
| E-Mail |  | | | |

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Weitere Bezugspersonen oder Vertretung** | | | | | | | | | | | | |
|  | Kontaktperson | | | |  | Beistand | | | |  | andere | |
| Name | |  | | | | | Vorname | | |  | | |
| Strasse | |  | | | | | PLZ, Wohnort | | |  | | |
| Tel. Privat | |  | | | | | Tel. Gesch. | | |  | | |
| E-Mail | |  | | | | | Tel. Mobil | | |  | | |
| Hausärztin/Hausarzt | | | | | | | | | | | | |
| Name | |  | | | | | Vorname | | |  | | |
| Strasse | |  | | | | | PLZ, Wohnort | | |  | | |
| Telefon | |  | | | | | | | | | | |
| Krankenkasse 2) | | | | | | | | | | | | |
| Name | | \_     \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | PLZ, Ort | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |
| Mitgliedernummer | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | |
| Bemerkung | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | |
| Ort / Datum | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | Unterschrift | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

**1) Kopie des Sozialversicherungsausweises beilegen**

**2) Kopie der Versicherungskarte Ihrer Krankenkasse beilegen (Vorder- und Rückseite)**

**Ermächtigung zur Auskunft**

**Sie ermächtigen die Verwaltung des Alterszentrums Kehl, sämtlichen Behörden und Amtsstellen die gewünschten Auskünfte zu erteilen.**

Bitte senden Sie das Anmeldeformular und die Kopien an:

|  |  |
| --- | --- |
| Alterszentrum Kehl  Bewohneradministration  Im Kehl 7  5400 Baden | Tel. 056 200 28 28 Fax 056 200 28 29  [info@daskehl.ch](mailto:info@daskehl.ch)  [www.daskehl.ch](http://www.daskehl.ch) |