Maple Point
1000 North Union Street
Monticello, IL 61856

APPLICATION FOR ADMISSION

I.
NAME OF APPLICANT:____
Last First Middle

AGE_____ BIRTHDATE________ MALE:____ FEMALE:____ MARITAL STATUS:______________

LAST ADDRESS:____

BIRTHPLACE:_____________ SPOUSE NAME:______________________________

RESIDENT'S PREVIOUS OCCUPATION:______________________________

MILITARY SERVICE-BRANCH-DATE:______________________________

FATHER'S NAME______________________________ MOTHER'S MAIDEN NAME____________________

RELIGION: ______________________________

SOC. SEC. #______________________ MEDICARE #______________________________

PUBLIC AID RECIPIENTS ONLY: MEDICAID # __________ RECIPIENT #____________________

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PERSON TO CONTACT IN CASE OF EMERGENCY - 1ST PERSON

NAME________________________ RELATIONSHIP_____________ HOME PHONE:__________________

ADDRESS______________________________ CITY__________________________ ZIP__________________

EMPLOYER____________________ CITY__________________ WORK PHONE:______________________

E-MAIL ADDRESS:______________________________

2ND PERSON

NAME________________________ RELATIONSHIP_____________ HOME PHONE:__________________

ADDRESS______________________________ CITY__________________________ ZIP__________________

EMPLOYER____________________ CITY__________________ WORK PHONE:______________________

3RD PERSON

NAME________________________ RELATIONSHIP_______ HOME PHONE:________________________

ADDRESS______________________________ CITY__________________________ ZIP__________________

EMPLOYER____________________ CITY__________________ WORK PHONE:______________________

II. ELIGIBILITY:

IS APPLICANT A RESIDENT OF PIATT COUNTY? YES ____ NO ____ HOW LONG _____ Yrs.

IS APPLICANT A LAND/HOME OWNER OF PIATT COUNTY? YES ___ NO ____ HOW LONG _______

IS APPLICANT A RELATIVE OF A PIATT COUNTY RESIDENT? YES ____ NO _____

NAME OF RELATIVE:____________________ RELATIONSHIP TO APPLICANT:____________________

ADDRESS:____ PHONE:______________________________

WHERE IS APPLICANT RESIDING NOW? ____

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III. MEDICAL HISTORY

NAME OF PHYSICIAN:____

DOES APPLICANT HAVE: A HISTORY OF:

MENTAL RETARDATION? YES _________ NO __________

MENTAL ILLNESS? YES _________ NO __________

DEVELOPMENTAL DISABILITY? YES ________ NO___________

Nature of Illness, State of Health

Heart Disease _______
Heart Failure _______
High Blood Pressure _______
Alzheimer's Disease _______
Dementia other than Alzheimer's ___
Stroke ______
Cancer ___
Seizures ____
Other ______________________
____
____
____

Emphysema ______
Chronic Obstructive Lung Disease ________
Glaucoma _________
Arthritis ___________
Diabetes Melletus _________
Osteoporosis _______
Food & Medication Allergies (List)
____
____
____
____
____

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Advanced Directives: (Check those items which the applicant has)

Power of Attorney - Healthcare _____
Power of Attorney - Property ______
Living Will _____
Feeding Restrictions________

Do Not Resuscitate ______
Medication Restrictions ___________

Organ Donation _______
Autopsy Request ___________

Funeral Home: ____ Phone Number: ___________

IV. FINANCIAL DATA:

Financial Responsibility By: Patient _______ Guardian _________ Power of Attorney _________

Public Aid _______ Family ____________

Other (Explain) ____
IS APPLICANT RECEIVING PUBLIC AID ASSISTANCE? YES ________ NO _________

If 60 day finances are not available, (approximately $6,500) have you made contact with the Healthcare and Family Services? YES _____ NO _____ WHEN ____________

INSURANCE

A. Life Insurance Company (Value)

__________________________ $ _________________

__________________________ $ _________________

__________________________ $ _________________

B. Medical Insurance Premium: $ _________________
Company ____________________________

Medicare Part D Premium $ _________________
Company ___________________________

C. Long-Term Care (Supportive Living) Insurance
Company ____________________________
1) Is a hospital stay required? ____________
2) Daily benefit payment $______________
3) Coverage period (circle)
1 yr. 2 yrs. 3 yrs. Other________

INCOME MONTHLY INCOME

A. Social Security - Applicant $___________
Social Security - Spouse $___________

B. Pensions (List Source)

______________________________ $___________

______________________________ $___________

C. Annuities, Etc. Monthly Income

______________________________ $___________

D. Other Income (Describe)

______________________________ $___________

TOTAL MONTHLY INCOME $___________

ASSETS

A. Cash/Savings/CD's (Bank) (Value)

______________________ $__________

______________________ $__________

______________________ $__________

B. Investments (Stocks, Bonds) (Value)

______________________ $__________

______________________ $__________

______________________ $__________

C. Real Estate/Farms (Description) (Location)

____________________ ____________________

____________________ ____________________

D. Other Assets (Description)

(Value)

____________________ $__________

____________________ $__________

TOTAL ASSETS $__________

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V. LIABILITIES

Mortgage______________________ $__________

Installment Payments $__________

Other (Describe)__________________ $ __________

TOTAL LIABILITIES $ __________

Is applicant physically and mentally able to understand and sign a contract with Maple Point for his/her care? ______________

I hereby authorize Maple Point to contact my physician or other healthcare entities to obtain past medical information and hereby release all persons from any liability due to furnishing such information.

I (we) certify and attest that the information provided, pages 1 thru 5 of this Application For Admission, is complete and correct. I (we) agree and understand that any material misstatement or omission may, at Maple Point's option, render any contract subsequently entered into between Maple Point and resident(s) null and void.

SIGNED BY: ____

NAME RELATIONSHIP

____

ADDRESS

____

HOME PHONE WORK PHONE

RECEIVED BY: ________________________ DATE RECEIVED: ____________________

OFFICE USE ONLY

________ PLACED ON WAITING LIST _______________

DATE

________ DENIED ADMISSION REASON ______________________________

COMMENTS: ____

____

____

FOLLOW-UP CONTACTS:

DATE	PERSON CONTACTED	RESULTS/REASONS