MAPLE POINT/PIATT COUNTY NURSING HOME
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:_____

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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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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

_____

_____

_____

RACE AND ETHNICITY DATA COLLECTION

Title VI of the Civil Rights Act of 1964 requires "Race and Ethnic" data collection from beneficiaries of federally assisted programs. Please note "Disclosure Clause" below:

"The following information is requested by the federal government in order to monitor compliance with Federal laws prohibiting discrimination against applicants seeking to participate in the program. You are not required to furnish this information, but are encouraged to do so. This information will not be used in the evaluation of your application or to discriminate against you in any way. However, if you choose not to furnish it, Management is required to note race/ethnicity on the basis of visual observation or surname".

If you do not wish to provide the information, please check the box below:

____I do not wish to furnish this information.

Ethnicity: (Mark only one)

_____Hispanic or Latino
_____Not Hispanic or Latino

Race: (Mark one or more)

_____American Indian/Alaskan Native
_____Asian
_____Black or African American
_____Native Hawaiian or Other Pacific Islander
_____White

Gender:

_____Male _____Female

_____Information provided by Management.