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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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_____

MONTHLY INCOME

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 _____ APPROVED _____
DATE

_____ DENIED ADMISSION REASON _____

COMMENTS: _____

_____

_____

FOLLOW-UP CONTACTS:

DATE	PERSON CONTACTED	RESULTS/REASONS