Mason County's Oakview MEDICAL CARE FACILITY

# ADMISSIONS APPLICATION

## INFORMATION & INSTRUCTIONS

### General

Oakview's receipt of this application does not guarantee placement, however, it confirms that the applicant's information has been received for admission review and an Oakview staff member will be in touch with you regarding our waiting list and admission procedure. Thank you in advance for your interest, input and cooperation.

### Pre-Admission Screening

A pre-admission screening is required by Federal OBRA regulations for individuals seeking to place a resident in a nursing facility who have a serious mental illness or a developmental disability. The applicant's primary care physician will need to assist with completing the necessary pre-admission screening paperwork (commonly referred to as PASARR or Forms 3877 and 3878). Time delays are to be expected if it is determined that a full Level II Assessment is needed.

### Chest X-Rays

A chest x-ray must only be completed 90 days or less prior to the date of admission to a skilled nursing facility if the resident is a known positive reactor for tuberculosis. If an x-ray is needed and this has not already been done, you will need to contact your physician regarding this matter.

### Non-Smoking Facility & Campus

Oakview Medical Care Facility, including the Sutter Living Center, is a non-smoking facility and campus.

### Application Submission

Please complete this application and return to Oakview

**By Mail**: Attn: Admissions
Oakview Medical Care Facility
1001 Diana Street
Ludington, MI 49431

**or**

**By Fax**: 231.843.7899

### Contact Information

If you have questions regarding the completion of this form, please contact our Admissions Office at: 231.845.5185, ext. 227.

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***PLEASE COMPLETE PAGES 2 - 4 IN FULL***

## PART A. APPLICANT PERSONAL INFORMATION

| Applicant's Full Name (Last, First, MI) | | | Date |
|---|---|---|---|
| Social Security # | Birth Date | Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced | |
| Legal Address (Street / Box Number) | | | Contact Phone |
| City | State | Zip | County of Residence |

Currently residing (Please check one)

- ☐ Adult Foster Care: _____
- ☐ Assisted Living: _____
- ☐ Home/Independent
- ☐ With Family Member: _____
- ☐ Hospital/Rehabilitation: _____
- ☐ Nursing Home: _____
- ☐ Psychiatric Facility: _____
- ☐ Other (Please list): _____

## PART B. APPLICANT BACKGROUND

**Military**

Is Applicant a Veteran? ☐ Yes ☐ No

Is Spouse a Veteran? ☐ Yes ☐ No

If yes, spouse's name & DOB:

If yes to either, branch of service: ☐ Army ☐ Navy ☐ Airforce ☐ USMC ☐ Coast Guard

## PART C. LEGAL INFORMATION

Does Applicant have any of the following?

(Please check all that apply and ***send or attach copies***)

- ☐ Court Appointed Conservator
- ☐ Court Appointed Guardian
- ☐ Financial DPOA
- ☐ Health Care DPOA
- ☐ Living Will
- ☐ Other Written Advance Directives (regarding life support issues)

## PART D. MEDICAL INFORMATION

| Current Primary Care Physician Name | | Phone Number |
|---|---|---|
| Physician Office/Hospital | Date of Last Hospital Admission | |

Ever been admitted to a Nursing Home? ☐ Yes ☐ No

| Name of Nursing Home | Dates of Nursing Home Stay | Contact Number |
|---|---|---|
| | | |

## PART D. MEDICAL INFORMATION (continued)

| | |
|---|---|
| Is the prospective resident aware of this application? | ☐ Yes ☐ No |
| Does the prospective resident use tobacco products? | ☐ Yes ☐ No |
| If yes, is applicant agreeable to quitting? | ☐ Yes ☐ No ☐ N/A |
| Is resident a known positive reactor for tuberculosis? | ☐ Yes ☐ No |
| If yes, date of last chest x-ray: | ☐ N/A Date: |

**Does the prospective resident have a Dementia diagnosis?** ☐ Yes ☐ No

If yes, please list the diagnosing Physician:

Current Diagnoses (Please select all that apply)

| | | | |
|---|---|---|---|
| ☐ Arthritis | ☐ Diabetes | ☐ Hyper/Hypo-thyroid | ☐ Osteoporosis |
| ☐ Cognitive Deficit | ☐ Epilepsy | ☐ Hyperlipidemia | ☐ Parkinson's |
| ☐ Congestive Heart | ☐ Heart Disease | ☐ Kidney Disease | ☐ Stroke |
| ☐ COPD | ☐ High/Low BP | ☐ Macular Degeneration | ☐ Other (Please list below): |
| ☐ Cancer | ☐ Huntington's | ☐ Multiple Sclerosis | _____ |
| Type: _____ | | | _____ |

Please list Other diagnosis (if applicable):

Current Medications & Dosages (If necessary, please include additional medications on a separate page)

Known Allergies (Please list)

| | |
|---|---|
| Does applicant currently have or receive the following? (Check all that apply) | ☐ Amputation ☐ Peg tube/ JG tube<br>☐ Catheter ☐ Routine Injections<br>☐ Dialysis ☐ Tracheotomy<br>☐ Hospice Services ☐ Ventilator or Respirator<br>☐ Ostomy bag ☐ Wound Care` |
| Any current evidence or history of? (Check all that apply) | ☐ Behavioral Problems / Issues<br>☐ Confusion<br>☐ Dementia or Alzheimer's Dementia<br>☐ Developmental Disability / Mental Retardation<br>☐ Hallucinations / Paranoia<br>☐ Mental Illness<br>☐ Substance Abuse |

If you checked any of the above, please give a brief explanation:

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## PART E. INSURANCE INFORMATION

***IMPORTANT: Please provide or attach copies of ALL INSURANCE CARDS (front and back)***

Please check any of the following that the applicant currently receives:

| | | |
|---|---|---|
| ☐ Medicaid | Medicaid Number | |
| ☐ Medicare Part A | Card Date | Medicare Number |
| ☐ Medicare Part B | Card Date | |
| ☐ Medicare Part C (Medicare Advantage) | Card Date | Plan Number |
| ☐ Medicare Part D (Prescription) | Prescription Plan Name | Prescription Plan Number |
| ☐ SSI Recipient | | |
| ☐ Veteran's Benefits | Please list beneficiary information | |

| | |
|---|---|
| Have you, or will you be, applying for Michigan Medicaid? | ☐ Yes ☐ No |
| If yes, please list date applied: | ☐ N/A Date: |

**Other Insurance**

| | | | |
|---|---|---|---|
| Type of Insurance | | Name Listed on Insurance Card | |
| State | Contract Number | Group Number | Service Code |
| Insurance Company's Address | | | |

## PART F. CONTACT PERSONS

| | | |
|---|---|---|
| 1. | First and Last Name | Relationship |
| | Mailing Address | |
| | Email Address | ☐ Home Phone ☐ Cell Phone |
| 2. | First and Last Name | Relationship |
| | Mailing Address | |
| | Email Address | ☐ Home Phone ☐ Cell Phone |

| | |
|---|---|
| Name of person submitting application | Relationship to prospective resident |

**For Admissions Office Use Only**

| | | | |
|---|---|---|---|
| **Placement:** | ☐ **OMCF Skilled Nursing Unit** | ☐ **SLC Alzheimer's/Dementia Unit** | ☐ **Unknown** |