St.Mary'sVilla
Since 1924

SKILLED NURSING & REHAB APPLICATION

Name__________________________________ Date of Birth____________________ Age____________

Address____
Street/R.R. Box No.

____
Town State Zip Township County

Phone_____________________________ Marital Status M W S D Sex___________________

Birthplace_________________________________ Social Security Number_________________________ Two (2) persons to contact in case of emergency:

____
Name Relationship

____
Address

____
Home Phone Other Phone

____
Name Relationship

____
Address

____
Home Phone Other Phone

Other relatives/special friends, address, phone number:

1. ____
2. ____

Power of Attorney____
Name Relationship

____
Address Phone

***Please provide a copy of the POA paperwork**

POWER-OF-ATTORNEY HAS AUTHORITY TO MAKE MEDICAL DECISIONS Yes No

POWER-OF-ATTORNEY HAS AUTHORITY TO MAKE FINANCIAL DECISIONS Yes No

DOES APPLICANT HAVE A LIVING WILL? ***If yes, please provide a copy.** Yes No

PHYSICIAN____
Name

____
Address Phone

DENTIST____
Name

____
Address Phone

FUNERAL
DIRECTOR____
Name

____
Address Phone

PASTOR____
Name Church Attended Phone

SOCIAL INFORMATION

WHAT ARE PRESENT LIVING ARRANGEMENTS?

____

____ DO
YOU HAVE PETS? YES NO IF YES, SPECIFY______________________________

DO YOU EXPECT YOUR ADMISSION TO OUR FACILITY TO BE?
GREATER THAN 6 MONTHS LESS THAN 6 MONTHS

HAVE YOU BEEN RECEIVING ANY HOME CARE SERVICES, SUCH AS VISITING NURSE, MEALS ON WHEELS, HOMEMAKER SERVICES? YES NO IF YES, PLEASE CIRCLE OR LIST BELOW:

____

DO YOU OWN YOUR EQUIPMENT? YES NO IF NO, DO YOU RENT? YES NO
WHEELCHAIR BED WALKER BEDSIDE COMMODE CANE OTHER___________

____

WHAT ARRANGEMENTS WILL YOU HAVE UPON DISCHARGE? HOME RELATIVE'S HOME
BOARDING HOME OTHER____

WHO WILL PROVIDE TRANSPORTATION TO OUTSIDE MEDICAL APPOINTMENTS? IF ST. MARY'S VILLA, SEE CHARGE SHEET FOR RATES___________________________________

EDUCATION____

OCCUPATION____

HOBBIES/INTERESTS____

WHAT RECREATIONAL ACTIVITY WOULD YOU LIKE TO PURSUE DURING YOUR STAY?

____

WHY DO YOU NEED LONG TERM CARE AT THIS TIME?_______________________________

____

PERSONAL HABITS: SMOKER ALCOHOL USE OTHER_______________________

____

COMMENTS/OTHER SPECIAL NEEDS____

____
____
____
____

MEDICAL INFORMATION

DIAGNOSIS____

____ **MOST RECENT HOSPITALIZATIONS**

HOSPITAL	REASON	DATES

1.____

2.____

3.____

4.____

MEDICAL HISTORY

1. CANCER
2. FRACTURE
3. STROKE
4. TUBERCULOSIS
5. PSYCHIATRIC TREATMENT
6. HIGH BLOOD PRESSURE
7. SEIZURES

WHAT SPECIAL TREATMENTS, THERAPY, OR MEDICATIONS DO YOU PRESENTLY RECEIVE?____
____
____
____

DO YOU HAVE ANY ALLERGIES TO FOOD, MEDICATION, ENVIRONMENTAL? ______YES ______NO IF YES, SPECIFY___________
____

DATE OF LAST PHYSICIAN OFFICE VISIT___________________________________
REASON____
RESULTS____

NURSING NEEDS

AMBULATION: WALKS ALONE WALKS WITH ASSISTANCE BED TO CHAIR ONLY NON-AMBULATORY

PATIENT AIDS: WALKER WHEELCHAIR CANE BRACE CRUTCHES HEARING AID
OTHER____

ORIENTATION: NEVER CONFUSED SOMETIMES CONFUSED ALWAYS CONFUSED
ABLE TO COMMUNICATE NEEDS

BEHAVIORAL: WELL ADJUSTED DEPRESSED COOPERATIVE HOSTILE COMBATIVE WITHDRAWN

BOWEL/ USES BATHROOM ALONE NEEDS HELP CATHETER **BLADDER:**
COLOSTOMY INCONTINENT OF URINE INCONTINENT OF FECES
OCCASSIONAL INCONTINENCE USED BEDPAN USES BEDSIDE COMMODE
CONSTIPATION LAXATIVE TAKEN AT HOME

DRESSING: DRESSES SELF DRESSES WITH SUPERVISION MUST BE DRESSED

BATHING: BATHES SELF BATHES WITH HELP TUB SHOWER COMPLETE BED BATH

EYESIGHT: NORMAL IMPAIRED GLASSES CONTACT LENSES BLIND

HEARING: NORMAL IMPAIRED DEAF

DENTITION: OWN TEETH DENTURES UPPER LOWER

DIET: REGULAR SPECIAL DIET POOR APPETITE FEEDS SELF
MUST BE FED REQUIRES HELP TUBE FED

FOOD PREFERENCES____

FOOD INTOLERANCES____

DISABILITIES____

SKIN: OPEN AREAS RED AREAS ANY SPECIAL PROBLEMS?____________________

____

____

FINANCIAL

PRESENT INCOME	**MONTHLY VALUE**
SOCIAL SECURITY_________________________CLAIM #__________________	$______________________
SUPPLEMENTAL SECURITY INCOME__________________________________	$______________________
PRIVATE PENSIONS____	$______________________
INTEREST INCOME____	$______________________
OTHER____	$______________________

ARE YOU RECEIVING SUPPLEMENTAL SECURITY INCOME? YES NO

FINANCIAL ASSETS

BANK CHECKING ACCOUNT____	$______________________
BANK SAVINGS ACCOUNT____	$______________________
REAL ESTATE____	$______________________
SAVINGS BONDS, STOCKS, CERTIFICATES____________________________ ____	$______________________
OTHER____	$______________________

WHO WILL RECEIVE BILLING AND FINANCIAL INFORMATION?____

HAVE ANY ASSETS BEEN TRANSFERRED IN THE PAST FIVE (5) YEARS? YES NO IF YES, PROVIDE DATE:

____

SPECIFY____

INSURANCE INFORMATION

MEDICARE #_______________________HOSPITAL (PART A)_________________MEDICAL (PART B)_______________

BLUE CROSS CONTRACT #_________________________GROUP #___________________OTHER____________________

BLUE SHIELD____

MEDICAL ASSISTANCE #___________________________PACE YES NO EXPIRATION DATE__________________

MEDICARE PART D PRESCRIPTION PLAN: NAME____________________________#'S_____________________________

OTHER MEDICAL INSURANCE? NAME OF POLICY____________________________POLICY #______________________

LIFE INSURANCE: NAME OF POLICY_______________________________________POLICY #______________________

DATE POLICY WAS ACQUIRED___________________FACE VALUE_______________CASH VALUE_________________

BURIAL ASSOCIATIONS____

SIGNATURE OF PERSON COMPLETING APPLICATION____

____

ADDRESS PHONE RELATIONSHIP TO APPLICANT

WHO SHOULD BE CONTACTED FOR ADMISSION____

DATE APPLICATION COMPLETED____

St. Mary's Villa Nursing Home

RATE AND CHARGE SCHEDULE

RATE: **$325.00 (Three Hundred and Sixteen Dollars) per day**

RATE INCLUDES:

1. Room & Board (includes three meals plus snacks)
   Rooms subject to change when necessary.
2. Twenty-four (24) hours nursing care, services and supervision
3. Dressings, unless excessive
4. Special Diets
5. Shaves
6. Shampoos, hair sets (ordinary)
7. Supervised occupational therapy (arts, crafts, diversional)
8. Recreational, social and spiritual activities
9. Oxygen
10. Toilet articles (tissues, powder, mouthwash, shaving supplies, cosmetics, etc.)

CHARGES:

1. Physician's visits
2. Name tapes
3. IV's
4. Barber
5. Beautician's services
6. Travel to clinics, hospitals, etc. when provided by the Villa
7. Prescription medications and hospital supplies
8. Cable for personal television sets.
9. Initial telephone installation (by approval of the Administrator); re-installation when rooms are changed and monthly charges.
10. Other exceptional services as required; e.g., wheelchair/equipment replacements and services charges
11. Laundering of personal clothing

1. When possible, residents or responsible parties are to have identification labels on each article of clothing before admittance. Name labels can be purchased at the Switchboard Area when necessary.
2. In the event a resident is on a "leave of absence", we will reserve his/her room and bill for the total days unless the nursing home is notified otherwise.
3. If a three-day notice is not given for unauthorized discharge, billing is made for those days.

I have read the above and agree to comply with these regulations.

____ ______________________

Responsible Party Date

NOTE: Above rates, charges, room changes and information are subject to change when necessary. You will be notified in advance.

01/07—Reviewed/Revised: 01/08
Reviewed/Revised: 01/09
Reviewed/Revised: 03/09
Reviewed/Revised: 01/10
Reviewed/Revised: 01/11
Reviewed/Revised: 01/12; 01/13; 01/14; 01/15; 1/16; 1/17; 1/18, 1/19