ADMISSION FORMS

On behalf of Bethesda we would like to thank you for your interest in the Application for Admission for our skilled nursing communities. As a not-for-profit health care organization, we have served our community for over 125 years by fostering successful aging through compassion and innovation.

Below are the admission form instructions to complete the application process that are required for admission approval. Please print and complete all forms. Once received, we will review and respond to the designated contact for further questions and approval needs. Please contact the Admission Counselor at selected community with any questions.

INSTRUCTIONS

1. **Application for Admission** (2 pages): Please complete all requested information as completely as possible. Financial information concerning sources of income is required to process along with signature and date.
2. **CPR / Treatment Directive**: This form is utilized if the resident goes into cardiac / respiratory arrest.
    - Check box A on the form if the resident wishes for all life saving measure to be used in the event their heart and breathing would stop. This would include CPR, use of a defibrillator, and if indicated calling 9-1-1.
    - Check box B if the resident does not wish for extensive measure to be used in the event of cardiac or respiratory arrest.
    - Sign and date form and name of resident.
    - Leave physician name and signature line blank.
    - The second page of this form is for internal use only.

3. **Consent for Use and Disclosure of Health Information**: Used to specify who has permission to obtain personal health information concerning the resident. The resident of the resident's POA may sign this form. On the line listed, please list those individuals and their relation to the resident.

4. **Elopement / Wandering Evaluation**: This form is for the safely of the resident so the nursing staff is able to make an appropriate decision on the best neighborhood for your loved one.

Additional required items upon move in:

- Social security, Medicare and current insurance cards.
- Financial Power of Attorney (POA) and Durable Power of Attorney (DPOA) or Living Will.
- A check payable to Bethesda + (name of community) is required for remaining days of current month and following month room and board current rate for Long Term Care, Respite and Assisted Living. An invoice will be supplied at admission.

Copies of all the above items can be made at the community during the completion of the pre-admission paperwork.

BETHESDA LONG TERM CARE INC.
APPLICATION FOR ADMISSION

Please check one: ❑ LTC/Skilled Nursing ❑ Memory Support ❑ Respite Care ❑ Hospice Care

Date of Application:_____ Anticipated Admission Date:_____

Full Name:_____ Preferred Name:_____

Address:_____ Social Security #:_____

City/State/Zip:_____ Medicare #:_____

Phone:_____ Medicaid #:_____

Present Location:_____ Birthdate:_____Age:_____

Referred By:_____ Marital Status: (circle) M W D S

Responsible Party:_____ Relationship:_____

RP Address:_____ City/State/Zip:_____

Email:_____ Cell Phone:_____

Home Phone:_____ Work Phone:_____

Current Pharmacy:_____ Transition to Omnicare Pharmacy: ❑Yes ❑No

To be notified in case of emergency: (Name, Address, Zip, Phone Numbers, Relationship, Email)

1._____

2._____

3._____

HEALTH INSURANCE & PHYSICIANS (COPIES OF ALL CARDS WILL BE MADE)

Primary Insurance:_____ ID#:_____

Secondary Insurance:_____ ID#:_____

Current Physician:_____Phone:_____

FUNERAL INFORMATION

Name of Funeral Home:_____ Has the funeral home been prepaid? ❑Yes ❑No

FINANCIAL INFORMATION & RESOURCES

Social Security Income per month $_____ VA Pension $_____ Private Pension $_____

Dividends $_____ Interest $_____ Other $_____

Long Term Care Insurance Provider:_____ Daily/Monthly Benefit:_____

Market Value of Stocks/Bonds/Retirement Accounts:_____

Name of Bank_____ Balance $_____ ❑Checking ❑Savings

Name of Bank_____ Balance $_____ ❑Checking ❑Savings

Name of Bank_____ Balance $_____ ❑Checking ❑Savings

Have you sold or given away any money, vehicles, property or any resource within the last 5 years?

❑Yes ❑No If yes: What:_____Value:_____ To Whom:_____

POWERS OF ATTORNEY – HEALTHCARE & FINANCES

Who manages your financial affairs?_____relationship:_____

Do you have a health care Power of Attorney? ❑No ❑Yes Designee:_____

Do you have a financial Power or Attorney? ❑No ❑Yes Designee:_____

Do you have a Legal Guardianship? ❑No ❑Yes Designee:_____

Do you have a Living Will? ❑No ❑Yes Please Submit Copies of All Documents

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The undersigned agrees to pay in ADVANCE the monthly charges rendered for room, meals and nursing services.

I hereby voluntarily apply for admission to _____. If I am admitted to this facility, I agree to comply with its rules and regulations, responsibilities and by-laws that may from time to time be established by it. I also expect the same consideration of rights stipulated in the Resident's Bill of Rights and Responsibilities. I understand that, if admitted, I am to remain in _____ only as long as my stay is agreeable both to Bethesda Health Group and to me.

I (we) hereby waive, relinquish, and abandon any and all claims, demands, suits or actions which I (we) may in the future have against Bethesda, its directors, agents, servants and employees, or any of them based upon any act or omission, occurring in connection with or arising as a result of the investigation of my (our) credit history and standing and financial responsibility herein authorized.

I do warrant that all foregoing statements, representations and declarations made by me are true; that I have fully and fairly answered each question therein contained and that I have not concealed or misrepresented any material fact.

_____ _____

Signature of Resident/Resident's Representative Date

Should the applicant, at some future date, be unable to meet the cost of the Bethesda Services, I (we), the undersigned, will assure the facility is notified 90 days in advance and that the undersigned will assure that the resident's assets are utilized for facility payment and that the undersigned will apply for Medicaid on behalf of the resident when the resident's funds become depleted.

_____ _____

Signature of Resident/Resident's Representative Date

_____ _____

Administrative Approval Date

❑BJ Extended Care ❑Eunice Smith
❑Dilworth ❑Meadow
❑Southgate ❑Village North

BETHESDA LONG TERM CARE
CPR/TREATMENT DIRECTIVE PHYSICIAN ORDER

Resident Name:_____ **I.D.#**_____

CARDIAC OR RESPIRATORY ARREST
Select status A or B in the event of Cardiac Arrest. If no option is chosen, CPR protocol will be initiated.

_____A. Cardiopulmonary Resuscitation ("CPR") protocol will be initiated.

_____B. No Cardiopulmonary Resuscitation ("CPR") protocol will be initiated.

IS THERE AN ADVANCED DIRECTIVE OR LIVING WILL ALREADY IN PLACE?

YES (Provide Copy) **NO**

_____ _____

Resident/Resident Representative Signature Date

Physician Signature Date

_____ _____

Print Name of Resident/Resident Representative

Print Physician's Name

- ❑ BJ Extended Care
- ❑ Dilworth
- ❑ Meadow
- ❑ Southgate
- ❑ Village North

Social Work will review code status annually with resident and/or resident representative. If no change in code status the Social Worker will document here to verify when review was completed and with whom.

Date of Review:	Review completed with:	Signature:	Date:

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Bethesda Health Group, Inc.

❑ Barnes Jewish Extended Care	❑ Bethesda Dilworth	❑ Eunice Smith Home
❑ Bethesda Meadow	❑ Bethesda Southgate	❑ Village North Retirement Community
❑ Charless Village Assisted Living	❑ Hawthorne Place Assisted Living	
❑ Bethesda Hospice Care	❑ St. Andrews & Bethesda Home Health	

Section A: Resident/Patient Information

Name:_____ Date of Birth:_____

Address:_____

Telephone:_____ Email: _____

Section B: To the Resident/Patient – please read the following statements carefully

Purpose of Consent: By signing this form, you consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. In addition, you will specify the individual(s) that may have access to your health information during your residency or the course of your treatment.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Administrator/Director/General Manager:_____Telephone:_____

Fax:_____

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will **Not** affect any action we took in reliance on this Consent before we received your revocation.

I give permission for the following person(s) to have access to my protected health information (PHI):

1. _____ **Relationship to me:** _____

2. _____ **Relationship to me:** _____

3. _____ **Relationship to me:** _____

4. _____ **Relationship to me:** _____

5. _____ **Relationship to me:** _____

6. _____ **Relationship to me:** _____

I have had the opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent for, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Signature:_____ **Date:**_____

If this consent is signed by a personal representative on behalf of the resident/patient, complete the following:

Print Personal Representative's Name: _____ Relationship:_____

NOTE: This consent form expires one year from date signed.

ELOPEMENT/WANDERING EVALUATION

Resident/Community Member Name:_____ Date_____

Anticipated Admission Date:_____

Definitions:

Elopement: When a resident/community member who is cognitively, physically, mentally, emotionally, and/or chemically impaired; wanders away, walks away, runs away, escapes or otherwise leaves a caregiving facility or environment unsupervised, unnoticed, and/or prior to their scheduled discharge.

1. Has the resident/community member ever eloped from their home/residence? ❑Yes ❑No
2. If yes – How many times have they eloped? _____

Elopement Risk: A resident/community member who is cognitively, physically, mentally, emotionally, and/or chemically impaired and has demonstrated an intent to wander away, walk away, run away or escape.

Wandering: The state of a resident/community member moving within their environment and into others' space with no discernible, rational purpose.

-Does the resident/community member currently wander? ❑Yes ❑No

-If yes – What time(s) of the day/night does the resident/community member usually wander?

_____

-If yes – Is the resident/community member difficult to redirect when they wander? ❑Yes ❑No

I, the undersigned, understand that based on the information given above that the resident's placement within the facility will be in:

❑ Long Term Care/Skilled Nursing ❑ Memory Support

If the resident is admitted to Long Term Care/Skilled Nursing or Assisted Living, I further understand that should elopement risk be demonstrated, on only one occasion, the resident/community member may be immediately transferred to a secure memory support neighborhood or fitted with an elopement alarm device for safety. The Resident Elopement/Wandering Evaluation Protocol will be followed. The resident will be placed on a visual check for a seventy-two (72) hour period. Following this evaluation period, the resident's level of care will be evaluated and altered as necessary. If the community determines the resident must be transferred to a secure unit and I disagree, the resident/resident's representative will be given a thirty (30) day written notice of discharge.

_____ _____ _____

Signature of Resident/Resident's Representative Relationship Date

❑ BJ Extended Care
❑ Charless Village
❑ Dilworth
❑ Eunice Smith
❑ Hawthorne Place
❑ Meadow
❑ Southgate
❑ Village North

White – Medical Record
Yellow – Business Office
Pink – Resident's Representative