

Application for Admission



Applicant Information

Full Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Social Security Number: _____ Date of Application: _____

Brock Health Release of Information Completed and Included? (attached) YES NO

Do you currently reside in another healthcare facility (Nursing Home, Rehab, Assisted Living, etc.)

Name of Facility: _____ Contact Name & Number: _____

Facility Applied To: (please check all that are applicable)

<input type="checkbox"/> Any/All	<input type="checkbox"/> Bayview Assisted Living 45 W Main St, Searsport	<input type="checkbox"/> Crawford Assisted Living 132 Middle Rd, Union
<input type="checkbox"/> East Point Assisted Living 96 Stackpole Dr, Machias	<input type="checkbox"/> Hilltop Assisted Living 462 Essex St, Dover-Foxcroft	<input type="checkbox"/> Lamp Memory Care Assisted Living 64 Lisbon St, Lisbon
<input type="checkbox"/> The Lodges Assisted Living 51 Main St, Springvale	<input type="checkbox"/> Pleasant Meadows Assisted Living 137 Park St, Dover-Foxcroft	<input type="checkbox"/> Prince Point 191 Foreside Rd, Falmouth
<input type="checkbox"/> Rising Hill Assisted Living 95 Access Hwy, Limestone	<input type="checkbox"/> Seal Cove 19 General Moore Way, Ellsworth	<input type="checkbox"/> Tissues Assisted Living 212 Fox Hill Rd, Athens
<input type="checkbox"/> Wellmore Point Assisted Living 40 Palmer St, Calais	<input type="checkbox"/> Bella Point Camden Assisted Living 51 Mechanic St, Camden	<input type="checkbox"/> Bella Point Bridgton 186 Portland Rd, Bridgton
<input type="checkbox"/> Bella Point Freeport 3 East St, Freeport	<input type="checkbox"/> Bella Point Fryeburg 70 Fairview Dr, Fryeburg	<input type="checkbox"/> Unsure

Applicant's Contacts and/or Responsible Party Information

Emergency Contact:

Name: _____ Relationship to Applicant: _____

Address: _____

Email Address: _____ Phone #: _____

Legal Guardian? YES NO Medical POA? YES NO Financial POA? YES NO

Contact #1:

Name: _____ Relationship to Applicant: _____

Address: _____

Email Address: _____ Phone #: _____

Contact #2:

Name: _____ Relationship to Applicant: _____

Address: _____

Email Address: _____ Phone #: _____

**Please attach copies of documentation showing POA/Legal Guardianship if applicable. Additional contacts can be added during the admission process.*

Applicant's Medical Information

Most Recent History & Physical Attached to this Application for Review (required): YES NO

Primary Medical Diagnosis: _____

Allergies: _____

Special Diet Information: _____

Living Will: YES (please attach) NO Do Not Resuscitate Order: YES (please attach) NO

Smoking Status (please note all our facilities are nonsmoking): Nonsmoker Former Smoker Current Smoker

Please List All Current Medications: Separate Medication List Attached

Table with 2 columns and 6 rows for listing current medications.

Provider Information

- a. Primary Care Provider Name: _____
a. Clinic Name: _____
b. Address: _____
c. Phone: _____ Fax: _____
b. Dentist Name: _____ Clinic Name: _____

Physical Status Information (please note none of these are disqualifying, this information is helpful for us to know.)

- a. Do you wear glasses: YES NO
b. Are you able to walk without assistance: YES NO
c. Are you able to walk with a cane/walker: YES NO
d. Are you able to bathe without assistance: YES NO
e. Are you able to dress without assistance: YES NO
f. Are you able to eat without assistance: YES NO
g. Are you able to handle all of your toileting needs without assistance: YES NO
h. Are you on any injectable medications: YES NO
i. Do you have any of the following- catheter, ostomy, skin wounds: YES NO

j. Other information regarding physical status and/or care needs:

Behavioral Health & Substance Use Information (please note none of these are disqualifying, this information is helpful for us to know.)

- a. Current or past behavioral health conditions (ex: anxiety, depression, bipolar, etc.): YES NO
- b. Current or past substance use disorders: YES NO
- c. Both behavioral health and substance use disorders: YES NO
- d. None to report:
- e. Prefer not to disclose:
- f. Please describe any current treatment, supports, or considerations relevant to care planning (optional):

Applicant's Financial Information

Do you manage your financial affairs independently? YES NO

If no, Name of Responsible Party: _____ Phone #: _____

Address of Responsible Party: _____

Payor Source: Long Term MaineCare Private/Self Pay

(If LTC MaineCare, please answer questions in section #1 below. If Private/Self Pay, please skip to #2.)

1. Long Term MaineCare Only

- a. Monthly Income: _____ Source(s): _____
- b. MaineCare ID #: _____
- c. Long Term MaineCare Application Completed? YES- Date Submitted to DHHS: _____ NO
- d. Maximus Assessment Completed and Included? YES- Date Completed: _____ NO
- e. DHHS Release of Information Completed and Included? (attached) YES NO
- f. DHHS Caseworker Information: Name: _____ Phone/Email: _____

2. Private/Self Pay Only

- a. Monthly Income: _____ Source(s): _____
- b. Financial Institution Name(s): _____
- c. Income Verification Form Completed and Included? (attached) YES NO
- d. Three (3) Months' Bank Statements Included? YES NO

I/We hereby certify that I/we have adequate assets to meet all anticipated expenses that may be incurred at this facility, for the following

time period: Less Than 1 Year 1-3 Years 4-5 Years Lifetime Other: _____

Please complete the following questions regardless of payment method

Applicant's Monthly Income/Benefits:

Social Security \$ _____ Interest/Dividends \$ _____

Pensions \$ _____ Estates/Trusts \$ _____

Annuities \$ _____ All other income \$ _____

Total Monthly Income \$ _____

Does your pension/annuity continue for surviving spouse? YES NO

Does your pension/annuity allow for annual adjustments? YES NO

Applicant's Assets:

Savings/Checking Accounts \$	Life Insurance with Cash Value \$
Stocks/Bonds \$	Certificates of Deposits \$
Trusts \$	Mutual Funds \$
Your Home (Estimated Equity) \$ Home Address if Applicable:	Additional Properties (Estimated Equity) \$ Property Address(es) if Applicable:
Other \$	

Have you sold or given away your home in the last 5 years? YES NO

Have you sold or given away a camp or land in the last 5 years? YES NO

Have you sold or given away a boat, motorcycle, snowmobile etc. in the last 5 years? YES NO

Have you given more than \$250 to your children or anyone else in the last 5 years? YES NO

If yes to any of the above, please explain: _____

I/we acknowledge that it is my/our responsibility to monitor my/our funds and will notify the facility 45 days in advance if applying for Medicaid, please ask for assistance from the facility. To the best of my/our knowledge, all the information on this application is complete and accurate. I/we understand that this information will be kept confidential and used only for the purpose of determining eligibility for residency. Payment for Assisted Living Services is due no later than the 5th of each month. The facility accepts two forms of payment, please indicate proposed payment method: ACH/ CC: _____

Name of Individual Completing/Assisting with Application: _____

Relation to Applicant/Referring Agency: _____



BROCK HEALTH
Assisted Living

AUTHORIZATION FOR RELEASE OF INFORMATION

Date: Facility:

Facility Address:

Resident Name: SS#:

I hereby authorize the above facility to provide information in accordance with the facility policy relating to my history, treatment, and services provided to me by the facility. This information may be released to the following service providers

- Hospital Mental Health Center
DMR Dentist
Podiatrist Medical Doctor
PT OT
RN Consultant Optometrist
Consulting MD Consulting MD
Psychiatrist Case Worker
Family Family
Home Health Ambulance Service
Pharmacy Other
Other Other

PointClick Care (for computerized data base)

Corporate Office (for computerized data base)

Note: This authorization expires not later than 30 months from the date of signing and may be revoked either orally or in writing by the resident or guardian at any time.

Expiration Date:

Resident/Guardian Witness Date
Review/Update Review/Update
Review/Update Review/Update

Revocation of Authorization (only sign below if revoking this release of information):

Resident/Guardian Witness Date



Authorization to Release Information

We are committed to the privacy of your information.
Please read this form carefully.

Which office(s) should help you? Please check.

<input type="checkbox"/> Office of MaineCare Services	<input type="checkbox"/> Office of Behavioral Health
<input type="checkbox"/> Office for Family Independence and Medical Review Team	<input type="checkbox"/> Office of Child and Family Services
<input type="checkbox"/> Maine Center for Disease Control and Prevention	<input type="checkbox"/> Office of Aging and Disability Services
<input type="checkbox"/> Dorothea Dix Psychiatric Center	<input type="checkbox"/> Division of Administrative Hearings
<input type="checkbox"/> Riverview Psychiatric Center	<input type="checkbox"/> Other:
<input type="checkbox"/> Division of Licensing and Certification	<input type="checkbox"/> Other:

Whose information will be disclosed? Please print clearly.

Individual's Name	Date of Birth		
Home Address	Town/City	State	Zip Code
Telephone	Email address of individual/personal representative (optional)		

Please check: Release/Send my information to: Obtain/Get my information from:

Name of Individual	Organization		
Address	City/State	Zip Code	
Telephone	Email address (optional)		

What is the purpose of the disclosure?

<input type="checkbox"/> Personal request	<input type="checkbox"/> To coordinate or manage my care
<input type="checkbox"/> For a legal matter, including testimony	<input type="checkbox"/> To see whether I qualify for insurance coverage, services, or benefits
<input type="checkbox"/> Other:	

To share the information with others by EMAIL, please read, initial and complete the following:

I understand that email and the internet have risks that the office sharing my information cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask to send my information by email. INITIALHERE _____
Please print the email address where you want your information sent:

What should be released or obtained about the individual named on this form? Please check all that apply.

<p><u>General permission:</u></p> <p><input type="checkbox"/> All health information from the office(s) checked above</p> <p><input type="checkbox"/> Insurance Claims or encounter data (information about visits to health care providers)</p> <p><input type="checkbox"/> Financial information including billing, payment, income, banking, assets</p> <p><input type="checkbox"/> Limit to the following date(s) or type(s) of information: (e.g., “Lab test dated June 2, 2025” or “Claims from 2024”) _____</p> <p><input type="checkbox"/> Other: _____</p>	<p><u>Special permission: Drug/Alcohol Treatment or Referral</u></p> <p><input type="checkbox"/> Include all drug/alcohol information in the release</p> <p><input type="checkbox"/> Include only the specific drug/alcohol records checked:</p> <p><input type="checkbox"/> Diagnosis and treatment</p> <p><input type="checkbox"/> Clinical notes and discharge summaries</p> <p><input type="checkbox"/> Drug/Alcohol history or summary</p> <p><input type="checkbox"/> Payment or claims information</p> <p><input type="checkbox"/> Living situation and social supports</p> <p><input type="checkbox"/> Medication, dosages or supplies</p> <p><input type="checkbox"/> Lab results</p> <p><input type="checkbox"/> Other: _____</p>
<p><u>Special permission: Mental/Behavioral Health Services</u></p> <p><input type="checkbox"/> Include this information in the release</p> <p><input type="checkbox"/> I want to review my mental health/behavioral health record before release. I understand that the review will be supervised.</p> <p>Please note: Maine law lets us share this information with other health care providers and health plans to coordinate and manage your care (to help take care of you). We will make a reasonable effort to notify you of the release.</p>	<p><u>Special permission: HIV/AIDS Status/Test Results</u></p> <p><input type="checkbox"/> Include this information in the release</p> <p>Please note: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if it is misused. Your HIV/AIDS-related information, and all of your data, will be protected as the law requires.</p>

I understand and agree that:

- I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.
- My treatment, payment for services, or benefits will not depend on whether I sign this form unless I am requesting or disclosing information to apply for benefits.
- “Information” may be in written, spoken and/or electronic format, and includes information about me from other healthcare providers (such as doctors, hospitals, and counselors) that is included in my files. My signature allows the people/offices named on the reverse to discuss my information for the purposes noted on this form.
- My information will be kept confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, a notice will be included with the records saying that such information may not be re-released or shared without my written permission.
- I may revoke (take back) my permission to release my information by filling out the Revocation Form found at <http://www.maine.gov/dhhs/privacy/index.shtml> and sending it to the office that shared my information. The Revocation Form is effective only after it is received and does not apply to information that was already shared.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance.
- This form expires **one year** from the date below unless I write an earlier date here: _____
- Additional releases of information are permitted until this form expires.

Please check: I affirm that the written or digital signature below is mine, and that I have the authority to sign this document.

Date: _____ **Signature:** _____

Printed name: _____

Personal Representative’s authority to sign: Parent Legal Guardian Conservator Other (Explain): _____



Income Verification Form

Name of Applicant: _____ Date: _____

POA (if applicable) _____ DOB: _____

Financial Information

Bank Name: _____

Account Type: Checking / Savings
(Please Circle One) Current Account Balance: \$ _____

Bank Name: _____

Account Type: Checking / Savings
(Please Circle One) Current Account Balance: \$ _____

Bank Name: _____

Account Type: Checking / Savings
(Please Circle One) Current Account Balance: \$ _____

Please list any assets: (vehicles, houses, stocks, bonds, life insurance policies)

Account Type	Estimated Value	Debts Against Asset
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

By signing this document you are authorizing Brock Health to contact all institutions listed on this form to verify balances and assets listed.

Signature _____

Date _____