Application for Admission

BROCK HEALTH
♦ Assisted Living ♦

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)*

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

Applicant's Contacts/Responsible Party Information

Emergency Contact:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #: _____

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

Contact #1:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #: _____

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

Contact #2:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #: _____

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

**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

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:

_____

_____

_____

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 three forms of payment, please indicate proposed payment method: ACH/ CC/ Check: _____

Long term Care Insurance (Private Insurance Policies may have provisions for coverage of Assisted Living Services) _____

Name of Individual Completing/Assisting with Application: _____

Relation to Applicant/Referring Agency: _____

Brock Health does not discriminate against otherwise qualified applicants for admission on the basis of race, color, creed, religion, ancestry, age, sex, marital status, national origin, disability or handicap, or veteran status.

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**.**

❒Office of MaineCare Services	❒ Office of Behavioral Health
❒Office for Family Independence and Medical Review Team	❒ Office of Child and Family Services
❒ Maine Center for Disease Control and Prevention	❒ Office of Aging and Disability Services
❒ Dorothea Dix Psychiatric Center	❒ Office of Administrative Hearings
❒ Riverview Psychiatric Center	❒ Other:
❒ Division of Licensing and Certification	❒ 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 Brock Health/DLTC/Bella Point			Organization Brock Health/DLTC/Bella Point
Address PO Box 1228 Camden ME 04843	Town/City	State	Zip Code
Telephone 207-594-4990	Email address (optional)		

What is the purpose of the disclosure?

❒Personal request	❒To coordinate or manage my care
❒For a legal matter, including testimony	❒To see whether I qualify for insurance coverage, services, or benefits
❒Other:	

To share the information with others by EMAIL, please 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**. INITIAL HERE _____**
Please print the email address where you want your information sent:

What information should be released or obtained? Please check all that apply.

General permission:	**Special permission: Drug/Alcohol Treatment or Referral for Services**
❒ **All** health information from the office(s) checked above ❒ Claims or encounter data (information about visits to health care providers) ❒ Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits ❒ Limit to the following date(s) or type(s) of information: (for example "Lab test dated June 2, 2019" or "Claims from 2018-2020") ❒ Other: _____	❒ Include **all** drug/alcohol information in the release ❒ Include only the **specific** drug/alcohol records checked: ❒ Diagnosis and treatment ❒ Clinical notes and discharge summaries ❒ Drug/Alcohol history or summary ❒ Payment or claims information ❒ Living situation and social supports ❒ Medication, dosages or supplies ❒ Lab results ❒ Other: _____
Special permission: Mental/Behavioral Health Services ❒ Include this information in the release ❒ I want to review my mental health/behavioral health record before release. I understand that the review will be supervised. **Please note**: Maine law allows us to share this information with other health care providers and health plans to coordinate and manage your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.	**Special permission: HIV/AIDS Status/Test Results** ❒ Include this information in the release **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.

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: _____
- This form permits additional releases until it expires.

Date: _____ Signature: _____

Personal Representative's authority to sign: _____

BROCK HEALTH INC
♦ Assisted Living ♦

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