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 live in another healthcare facility? ☐ YES ☐ NO

Name of facility: _____ Contact Name:_____

Address: _____ Phone:_____

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

☐ Any/All	☐ Lamp Memory Care Assisted Living, Lisbon	☐ Seal Cove, Ellsworth
☐ Bayview Assisted Living, Searsport	☐ The Lodges Assisted Living, Springvale	☐ Bella Point Bridgton
☐ Crawford Commons, Union	☐ Pleasant Meadows Assisted Living, Dover-Foxcroft	☐ Bella Point Camden Assisted Living
☐ East Point Assisted Living, Machias	☐ Prince Point, Falmouth	☐ Bella Point Freeport
☐ Hilltop Assisted Living, Dover-Foxcroft	☐ Rising Hill Assisted Living, Limestone	☐ Bella Point Fryeburg
☐ Wellmore Point Assisted Living, Calais	☐ Tissues Assisted Living, Athens	☐ 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 own financial affairs independently**?** ☐ YES ☐ NO
If no, name of Responsible Party: _____
Address:_____ Phone #: _____

Payor Source: ☐ **Long Term MaineCare** ☐ **Private/Self Pay**

ACH Form Completed? (attached, required for all admissions) ☐ YES ☐ NO

(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: _____ (Provide Bank statement where Income is deposited)
      Source(s): _____
   b. MaineCare ID #: _____ Mainecare #:_____ Other Insurance #:_____
   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: _____ (Provide Bank Statement where Income is deposited)
      Source(s): _____
   b. Mainecare ID:_____ Mainecare #:_____ Other Insurance #:_____
   c. Financial Institution Name(s): _____
   d. Income Verification Form Completed and Included? *(attached)* ☐ YES ☐ NO
   e. 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 our facility, for the following time period: Less than 1 year 1 to 3 years 3 to 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 $ _____

Mutual funds $ _____

Stocks/bonds $ _____

Your home (estimated equity) $ _____

Trusts $ _____

Home Address:_____

Certificates of Deposits $ _____

Additional properties (estimated equity) $ _____

Life insurance with cash value $ _____

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.