



Douglas Manor

Nursing and Rehabilitation Center

Application for Long-Term Care

First, Last Name: _____ Preferred Name: _____

Current Address: _____ City/State: _____

Zip Code: _____ Date of birth: _____ Age: _____ Place of Birth City/ State: _____

Telephone number: _____ Sex at Birth: Male / Female Marital status: _____

First, Last Name of Spouse: _____ Social Security number: _____

Registered voter: Yes / No. If yes name of City/ State: _____ Zip code: _____

Religious Preference: _____ Education: _____ Current/ Former Occupation: _____

Current/ Former Employer: _____ Date of Retirement: _____

Name of current Physician: _____ Address of Physician: _____

Veteran: Yes / No. Is spouse a Veteran: Yes / No.

First/ Last name of Children and current address:

First/ Last name, relation, and current address of family members involved in care:

Check off all the appropriate choice for the applicants former living arrangements:

Alone: _____ Home: _____ Assisted living: _____ Care services in place: _____ Spouse at home: _____ Family at home: _____

Other please provide specifics: _____

History of unprescribed drug dependence: Yes / No. History of Alcohol dependence: Yes / No.

If yes you marked yes to drug dependence or alcohol dependence, please provide details to drug name/ usage and/ or alcohol consumption (What and how much a day):

History of mental illness:

Any noted emotional issues (Anger, depression, mood changes)? If yes, please provide details:

Recent loss of a loved one in the last year? If yes, please provide details:

How does the applicant feel about placement at Douglas Manor for long-term care (Accepting, denial, angry, indifferent, unsure)? Please provide details below:

What community providers is the applicant receiving services from? Please provide agency names and contact numbers:

Current insurance information for applicant:

Medicare member ID number: _____

Managed Medicare ID number and Carrier (UHC, Connecticare, Anthem, Aetna):

Supplemental/ Part B member ID and Carrier (VA, Tricare, UHC, AARP):

Other insurance member ID/ Carrier: _____

Name of the Desired Funeral Home: _____ Phone number: _____

Person Responsible for Applicants Account:

First, Last Name: _____

Address: _____

City/ State: _____ Zip Code: _____

Home Phone number: _____ Cell phone Number: _____

Email address: _____

Relation to applicant: _____ Are you POA: Yes / No. Are you Conservator: Yes / No.

Emergency Contacts:

1. FIRST, LAST NAME AND RELATION TO APPLICANT:

Address: _____ City// State: _____

Zip Code: _____ Home phone number _____ Cell phone Number: _____

2. FIRST, LAST NAME AND RELATION TO APPLICANT:

Address: _____ City// State: _____

Zip Code: _____ Home phone number _____ Cell phone Number: _____

3. FIRST, LAST NAME AND RELATION TO APPLICANT:

Address: _____ City// State: _____

Zip Code: _____ Home phone number _____ Cell phone Number: _____

Medical History

Primary Diagnosis: _____

Is the individual aware of health status: Check the appropriate answer: Yes: _____ No: _____

Previous nursing home admissions: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Currently Hospitalized: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Current or previous psychiatric hospitalizations: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Is the applicant on Hospice services? Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Is the applicant on Antipsychotic medications: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Is the applicant on Antidepressant or antianxiety medications: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Any known drug allergies: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Is the applicant on Chemotherapy medications: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Has the applicant had any recent operations: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Present location of applicant: _____

How long has the applicant been at present location: _____

Reason for placement at present location: _____

Information Pertaining to applicant's personality and lifestyle:

Recent activities: _____

Volunteer activities: _____

Interests/ Hobbies: _____

Special talents: _____

Dislikes: _____

Favorite topic of conversation: Check the appropriate answer:

Family: _____ Grandchildren: _____ Sports: _____ Past events: _____ Other: _____

If above answer is other please provide details:

Applicants current function levels

Current mental status: Check the appropriate answer/ answers:

Alert: _____ **Confused:** _____ **Oriented:** _____ **Disoriented:** _____ **Aggressive:** _____ **Combative:** _____

Code status: Check the appropriate answer/ answers:

DNR: _____ **DNI:** _____ **Resuscitate:** _____ **has living will:** _____

Nursing information

Ambulation: Check the appropriate answer/ answers:

- _____ **Independent with or without assistive device**
- _____ **Walks with supervision with or without device**
- _____ **Walks with continuous physical assistance or support**
- _____ **Bed to chair with mechanical device (Non-ambulatory)**
- _____ **Bedfast**

May describe ambulation ability in more detail here: _____

Transferring: Check the appropriate answer/ answers:

- _____ **No assistance**
- _____ **Uses assistive device with on hands on assistance (walker or cane)**
- _____ **Supervision only**
- _____ **Requires transfer with or without equipment with assistance**
- _____ **Bedfast**

May describe Transferring needs in more detail here: _____

Bladder: Check the appropriate answer/ answers:

- _____ **Continent**
- _____ **Rarely incontinent (during night only)**
- _____ **Occasionally incontinent (once a week or less)**
- _____ **Frequently incontinent (up to once a day)**
- _____ **Totally incontinent**
- _____ **Has urinary catheter**

May describe bladder needs in more detail here: _____

Bowel: Check the appropriate answer/ answers:

- _____ **Continent**
- _____ **Rarely incontinent (during night only)**
- _____ **Occasionally incontinent (once a week or less)**
- _____ **Frequently incontinent (up to once a day)**
- _____ **Totally incontinent**
- _____ **Has ostomy**

May describe bowel needs in more detail here: _____

Bathing: Check the appropriate answer/ answers:

- _____ **No assistance**
- _____ **Supervision only**
- _____ **Assistance in/ out of tub/ shower with light hands on assistance while bathing**
- _____ **Requires total care by caregiver for tub/ shower**

May describe bathing needs in more detail here: _____

Dressing: Check the appropriate answer/ answers:

- _____ **No assistance**
- _____ **Supervision only**
- _____ **Light hands on assistance while dressing**
- _____ **Requires total assistance from care giver to get dressed**

May describe bathing needs in more detail here: _____

Feeding: Check the appropriate answer/ answers:

- _____ **No assistance**
- _____ **Supervision only**
- _____ **Light hands on assistance/ verbal ques**
- _____ **Requires total assistance from care giver to eat**

Does the applicant have Dentures: Yes / No

May describe bathing needs in more detail here: _____

Sight: Check the appropriate answer/ answers:

- _____ **Good**
- _____ **Vision is adequate- unable to read fine print**
- _____ **Vision is limited- Gross object differentiation**
- _____ **Blind**

Does the applicant have glasses: Yes / No

May describe vision needs in more detail here: _____

Hearing: Check the appropriate answer/ answers:

- _____ **Good**
- _____ **hearing slightly impaired**
- _____ **Limited hearing- must speak loudly**
- _____ **Virtually/ completely deaf**

Does the applicant have hearing aids: Yes / No

May describe hearing needs in more detail here: _____

Speech: Check the appropriate answer/ answers:

- _____ **Speaks clearly**
- _____ **Some deficits- usually gets message across**
- _____ **Unable to speak clearly or not at all**

May describe speech needs in more detail here: _____



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Financial Evaluation

First, Last name of applicant: _____

Applicant is admitting from: _____ Responsible party: _____

Home phone number: _____ Cell phone number: _____

Address: _____

City/ State: _____ Zip Code: _____.

Insurance information:

Medicare Number: _____ Medicaid number: _____

Pending T-19 application number: _____ Date and District applied: _____

Case workers name: _____

Case workers Phone number: _____

Case workers E-mail address: _____

Is applicant a private pay? Check off appropriate answer: Yes: _____ No: _____

Length of time applicant will be maintained as private pay: _____

Is the applicant a Veteran? Check the appropriate answer: Yes: _____ No: _____

Is the applicant's spouse a Veteran? Check the appropriate answer: Yes: _____ No: _____

Does the applicant own a Partnership- approved Long-Term Insurance policy? Check the appropriate answer: Yes: _____ No: _____

If the above answer is yes, What is the policy number: _____ Name of Carrier: _____

Amount of policy: _____ Phone number for policy: _____

Other health insurance:

Type: HMO: _____ Group: _____ Major Medical: _____ No Fault: _____ COBRA: _____

Company name: _____ Policy Number: _____

Company name: _____ Policy Number: _____

Company name: _____ Policy Number: _____

Coverage Notes:

Applicants own income:

Social Security: \$ _____ per month.

Mailed to provide address, city, state, and zip code: _____

Direct Deposit into Checking account: Yes / No. Direct Deposit into Savings account: Yes / No.

Amount of Pension: \$ _____ per month. Source: _____

Amount of Annuity: \$ _____ per month. Source: _____

Amount of Interest: \$ _____ per month. Source: _____

Dividends: \$ _____ per month. Source: _____

Other: \$ _____ per month. Source: _____

Does the applicant receive income from or have any interests in a Trusts? Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Does the applicant have any debt or obligations: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Does the applicant have any pending lawsuits filled or planned that might result in receipt of payment: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Applicants' assets:

Does the applicant have Real Estate; Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide address, city, state, and Zip Code:

Name: _____

Description: _____

Was this Real Estate the applicant's home prior to entering the facility: Check the appropriate answer: Yes: _____ No: _____

Is the applicants spouse now living in the home: Check the appropriate answer: Yes: _____ No: _____

Does the applicant have "Life Use" of any real estate, any ownership interests (in full or part) for his/ her lifetime, or the right to occupy property for his/ her lifetime: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

Does the applicant own any Automobiles or Vessels: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes, please provide details:

Make and Model: _____ Year: _____ Owner/s: _____

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Make and Model: _____ Year: _____ Owner/s: _____

Does the applicant own any Stocks and/ or Bond Certificates: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details(Describe type and approximate value):

Does the applicant own any Bank, Savings, or checking accounts: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details(Describe type and approximate value):

Does the applicant have any life insurance policies: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details(Describe type and approximate value):

Does the applicant have any other policies or assets of value not listed above: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details(Describe type and approximate value):

Does the applicant have any Burial or Agreement accounts Check the appropriate answer: Yes: _____ No: _____

If above answer is yes, please provide details:

Name of Funeral Home: _____ Amount: _____ Revocable: Yes / No Irrevocable: Yes / No

Name of Owner: _____

Name of Funeral Home: _____ Amount: _____ Revocable: Yes / No Irrevocable: Yes / No

Name of Owner: _____

Name of Funeral Home: _____ Amount: _____ Revocable: Yes / No Irrevocable: Yes / No

Name of Owner: _____

Name of Funeral Home: _____ Amount: _____ Revocable: Yes / No. Irrevocable: Yes / No.
Name of Owner: _____

Transfer of assets:

Within (60) sixty months prior to the date of this application, has the applicant or the applicant's spouse given away any assets of any kind (E.g. Cash, security checks, real estate, etc.) or transferred any assets of any kind for less than fair market value?

Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please describe fully all such gifts and/or transfers in excess of \$1,000 including the asset transferred, names, addresses, and relationship of the person to whom the gift or transfer was made to and the value of the gift and/ or transfer:

Within (60) sixty months prior to the date of this application, has the applicant or the applicant's spouse created any trusts and/ or placed funds and/ or any other assets in a trust that already existed?

Check the appropriate answer: Yes: _____ No: _____

If above answer is yes, please describe and provide a copy of the trust instrument:

I certify that I have fully investigated the applicants financial records and that this is a true and complete statement of the applicants current income, assets, any gifts, any transfers of less than the fair market value in excess of \$1,000, any trusts created, and or transfers of assets to any trust that the applicant and/or his/ her spouse has made.

Name of Patient/ Resident/ Responsible party

Date

that filled out the Financial evaluation

Signature of Patient/ Resident/ Responsible party

that filled out the Financial evaluation



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DOUGLAS MANOR COST SHEET

*The following costs are for individuals paying privately (Not utilizing insurance)
room and board*

Daily rate for private: \$435.00 a day

Daily rate for Semiprivate: \$412.00 a day

Note daily rate includes Room/ board, cable TV, local telephone calls, laundry, 24/7 medical staff/care.

In addition to daily room rate provided above, the below services are paid at a per- diem rate

Speech, Occupational, and/ or Physical therapy evaluations: \$80.00 for 15 minutes

Speech and/ or Occupational therapy session: \$60.00 for 15 minutes

Physical therapy session: \$40.00 for 15 minutes

Services as rendered:

- PHYSICIAN
- PHARMACY
- LABORATORY
- X-RAY
- OXYGEN
- PODIATRY
- DENTAL
- AUDIOLOGY
- PSYCHIATRIC

Thank you for considering Douglas Manor for you or your loved ones long-term care needs. If you have any questions, please contact Douglas Manor's Admissions Director.

Kevin Venturini

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