Douglas Manor
Nursing and Rehabilitation Center

Application for Short-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, 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.

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 activites:_____

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 **Does the applicant have Dentures: Yes / No**
_____ Supervision only
_____ Light hands on assistance/ verbal ques
_____ Requires total assistance from care giver to eat
May describe bathing needs in more detail here:_____

Sight: Check the appropriate answer/ answers:
_____ Good **Does the applicant have glasses: Yes / No**
_____ Vision is adequate- unable to read fine print
_____ Vision is limited- Gross object differentiation
_____ Blind
May describe vision needs in more detail here:_____

Hearing: Check the appropriate answer/ answers:
_____ Good **Does the applicant have hearing aids: Yes / No**
_____ hearing slightly impaired
_____ Limited hearing- must speak loudly
_____Virtually/ completely deaf
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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The above-named resident is considered to be a short-term placement with our facility. As such, you have elected to not provide us with a full financial disclosure of his/her income and assets at this time. If in the future it is determined that this resident is to be long term, this facility will require that you meet with a staff member of our Accounts Receivable Department to provide us with a full disclosure of the finances of this person. A staff member will call you within 30 days of this admission to review the short-term, long-term status and also, if appropriate, to make an appointment for you to come in to discuss this resident's finances. If for any reason this financial information cannot be attained, the facility will initiate a discharge plan for this resident. I have received the above notice and agree to provide a full financial disclosure at the time the above-named resident becomes long-term at this facility.

_____ _____

Name of Patient/ Resident/ Responsible party
that filled out the application

Date

_____

Signature of Patient/ Resident/ Responsible party
that filled out the application

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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 one's rehab & respite care needs. If you have any questions, please contact the Douglas Manor's Admissions Director.

Kevin Venturini
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