GRANDVUE
Charlevoix County Medical Care Facility

ADMISSION APPLICATION

Please complete this application and return to Grandvue Medical Care Facility at the address shown.
Receipt of this form does not guarantee a bed for the applicant; however, it confirms that the applicant's information has been received for admission review. We will be in touch with you regarding our waiting list and admission procedure. Thank you for your timely assistance and cooperation.

APPLICANT INFORMATION:

NAME: _____BIRTH DATE:_____/_____/_____
(legal name:_____)
(first) (middle) (last)

Home
Address: _____City:_____State:_____
Mailing
Address: _____City:_____State:_____
Telephone #:_____Alternate Telephone #:_____

County of Residence: _____

Applicant is currently at:_____(home)_____(hospital)_____(other)
Please identify facility (if applicable):_____
Address: _____
City: _____State:_____
Telephone #:_____
Dates of Stay: _____

INSURANCE INFORMATION: ***WE MUST RECEIVE COPIES OF ALL CARDS WITH THIS APPLICATION***
Social Security #:_____Medicare #:_____(A____B____)
Medicaid #:_____
Other Insurance: _____Supplemental:_____
Vision: _____Dental:_____Prescription:_____
Long Term care Insurance:
_____
Is this covered by workman's Comp? _____if yes, dates: _____
Is this covered by Auto Insurance?:_____if yes, dates: _____Company:_____
Applicant's payor source: _____if Medicaid, will you be applying: _____
Do you need assistance to apply? _____

1728 S. Peninsula Road * East Jordan, MI 49727 * phone 231-536-2286 * fax 231-536-2476

RESPONSIBLE PARTY INFORMATION:

Person responsible for handling/assisting with financial matters for the applicant:

Name: ____Relationship:________________________
Address: ____________________________________City:_________________State:_____Zip_______
Home Telephone #:_____________________Work #:_________________Cell:__________________

Emergency Contact Person Name: ____
Address:___________________________________City:__________________State:____ Zip______
Telephone #:____________________________other:____

Emergency Contact Person Name: ____
Address:___________________________________City:___________________State:_____Zip________
Telephone #:_____________________________other:____

DOES APPLICANT HAVE: Guardian – yes_____no_____ Conservator – yes____no____
Durable Power of Attorney (Healthcare & Financial) – yes_____no_____
Durable Power of Attorney (Healthcare only) – yes_____no_____
Durable Power of Attorney (financial only) – yes_____no_____
Living Will – yes_____no_____

If so, please complete:
Name:____Relationship:______________________
Address: ____City, State, Zip:___________________
Telephone #:____________________________________work #:_________________________________
Other #:____

IMPORTANT NOTICE

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**** WE MUST RECEIVE COPIES OF GUARDIANSHIP OR ALL POWER OF ATTORNEY PAPERS AND ADVANCE DIRECTIVES WITH THIS APPLICATION****

****

Name of Physician recommending placement: ____
Telephone #:___________________________________

Hospital (most recent stay):____
Dates of stay: ___________________________Inpatient:________________Observation:___________

Reason for hospital stay: ____

Other facility placement: yes_____no_____

Name of facility:
_____
Address:
_____City:_____State:_____
Telephone #:_____Contact:_____
Dates of Stay: _____
Reason for requesting admission to Grandvue Medical Care Facility: _____
_____
Current problem(s):_____
_____
How long has problem(s) existed:
_____
_____

Is applicant continent of bladder? _____ Is applicant continent of bowel? _____

Eyesight: good_____ adequate_____ poor_____ wears glasses_____
Last vision exam:
_____By:_____

Dental: own teeth_____ dentures_____ uppers_____ lowers_____ partials_____
Last dental exam:
_____By:_____

Hearing: wears hearing aids: right ear_____ left ear_____ adequate hearing_____

Appetite / Eating habits: good_____ independent_____ needs assistance_____ poor____

Special needs: oxygen_____ catheter / foley_____ other needs: _____

History of mental condition / occurrence or psychiatric need: _____
_____

possible behavioral needs: wanders___ easily redirected___ feels lost at times___
(check all that apply) prone to anger outburst___ easily accepts assistance___
gets along well with others___ enjoys group activities___
can express / Identify feelings___ feels isolated___
enjoys time alone___ reading___ watching TV___
other_____

Does the applicant know and understand their need for placement at Grandvue Medical Care Facility: _____
_____
_____

How can we help / assist the applicant and family with this need / decision for placement?
_____
_____
_____

Is there any information that we should or need to know regarding this applicant?
_____
_____
_____

Please sign and date: _____ _____/_____/_____
(signature) (date)

Thank you for your assistance and cooperation with this application!

(Along with this form, please be sure you have included: ***copies of all legal documentations as well as copies of all medical / insurance cards of applicant)***

Please mail to:
Admissions / Grandvue Medical Care Facility
1728 Peninsula Road
East Jordan, MI 49727

THIS APPLICATION IS VAILID FOR 45 DAYS UPON RECEIPT

If you have any questions please call (231) 536-2286 and ask for admissions….

"RESIDENT HISTORY"

In order to help us better acquaint ourselves with our new Residents, we would appreciate knowing more about their backgrounds. This information will be used during reminiscing time and is very helpful if the resident is talking about someone or an experience from the past. Some information may be especially helpful in developing a plan of care. Thanks for the information you can give us.

Resident Name: _____ Place of birth: _____ DOB: _____

Parents' Names: Mother _____ Father _____

Brothers (names/ages/causes of death if deceased) _____

_____

Sisters (names/ages/causes of death if deceased) _____

_____

Ethnic Background of Family: _____

Schooling of resident (place/highest grade/favorites, etc.) _____

_____

Spouse's Name: _____ Date/Place of Marriage: _____

Children (names, where they live): _____

_____

Resident's former occupation(s): _____

Last Employer: _____ How many years: _____

Other Work History: _____

Year Retired: _____ Shift Worked: _____

What does the resident remember most about his/her job? _____

_____

Veteran or spouse of veteran? _____ Branch of Service: _____ Years: _____

Active in Veteran Organizations: _____

Registered Voter? Yes _____ No _____ If yes, where? _____ If no, would resident like to be registered? Yes _____ No _____

Activity Interests:

Please place an "X" if interested. Place a "P" if a past interest only.

Physical Activities:
( ) Baseball
( ) Basketball
( ) Biking
( ) Boating
( ) Bowling
( ) Camping
( ) Dancing
( ) Fishing
( ) Football
( ) Golfing
( ) Hunting
( ) Running
( ) Sports Fan _____
( ) Swimming
( ) Tennis
( ) Other _____

Other:
( ) Bird Watching
( ) Clubs _____
( ) Dining Out
( ) Driving
( ) Pets _____
( ) People Watching
( ) Shopping
( ) Traveling
( ) Volunteer
( ) Computer

Music/Television:
( ) Music Preference _____
( ) TV Preference _____
( ) Radio Preference _____

Reading:
( ) Books _____
( ) Magazines _____
( ) Book Tapes _____
( ) Newspaper _____
( ) Religious _____
( ) Prefers Large Print

Arts/Crafts/Hobbies:
( ) Ceramics
( ) Crafts
( ) Drawing
( ) Handiwork _____
( ) Woodworking _____
( ) Collections _____
( ) Sewing _____
( ) Other _____

Games:
( ) Cards _____
( ) Video Games
( ) Bingo
( ) Other

Domestic:
( ) Baking _____
( ) Cooking _____
( ) Gardening _____

Likes groups: Yes _____ No _____ Likes doing things alone: Yes _____ No _____

Church Attended: _____ Attendance History _____ Religion of Choice _____

Are there any special religious symbols that are meaningful? (rosary, hymns, bible, crucifix, etc.) _____

_____

Are there any religious instructions you want us to know about? (last rites, anointing of the sick, always read the Bible in the morning, uses devotional materials daily, etc.)

_____

_____

Would resident desire contact with a priest/minister? _____

History of Coping:

Has the resident ever received mental health services: outpatient counseling, inpatient mental health unit, etc? _____ If yes, explain: _____

_____

Has resident ever been diagnosed with depression or anxiety: Yes _____ No _____
If yes, please explain:
_____

Has resident ever been diagnosed with any other mental health diagnosis? Yes _____ No _____
If yes, please explain:
_____

Does the resident now or has he/she ever in the past taken any type of medication for any of the above mental health conditions? (antidepressants, anti-anxiety, anti-psychotics): Yes _____ No _____
If yes, please list medications and date: _____

_____

Has resident ever attempted or threatened suicide? Yes _____ No _____ If yes, please explain: _____

_____

_____

Does resident now or has he/she ever in the past used alcohol or tobacco? Yes _____ No _____
If yes, please explain, listing amounts, frequency, type: _____

_____

_____

Has this resident ever experienced an addiction to any substance (alcohol, drugs, tobacco, etc.):
Yes _____ No _____ If yes, please explain: _____

_____

How does this person usually cope during difficult times? (crying, yelling, withdrawal, prayer, seek out family members, etc.) _____

_____

Losses in Life:

Recent: _____ Past: _____

How has resident dealt with them: _____

Does this person have any history of being abused (physically, emotionally, or sexually) that you are aware of? Yes _____ No _____
If yes, please explain: _____

_____

Has this resident had a history of abusing themselves? Yes _____ No _____ If yes, please explain:

_____

_____

_____

What are some accomplishments that he/she is especially proud of? _____

_____

_____

What are some disappointments that he/she wishes would or could have turned out differently?

_____

_____

_____

History of Trauma:

Has your loved one experienced traumatic events (combat in war; death of an infant, child, grandchild, etc.; unexpected death of loved one; auto accidents; fire; etc.) Yes _____ No _____

If yes, what _____

If yes, when _____

Does your loved one talk about traumatic events? Yes _____ No _____

Is there a particular time of year or season that is more difficult for your loved one? Yes _____ No _____

If yes, when _____

Behavior Pattern:

Any history of physical aggression (hitting, biting, kicking, slapping, pushing, etc.): Yes _____ No _____

If yes, describe _____
_____

Any known factors that may contribute to or provoke above behavioral issues? Yes _____ No _____

If yes, what? _____

Any particular time of day that is more difficult? Yes _____ No _____

If yes, explain _____

Any history of wandering? Yes _____ No _____ If yes, where? _____

If yes, when? _____

Any history of verbal aggression (making threats, yelling at, swearing at, etc.)? Yes _____ No _____

If yes, explain _____

_____

WHAT ELSE WOULD YOU LIKE TO TELL US ABOUT YOUR LOVED ONE THAT WOULD HELP US BETTER CARE FOR HIS OR HER NEEDS? _____

_____

_____

Are there any family issues that we should be aware of? _____ If yes, please explain:

_____

_____

_____

_____

Does anyone in the family need additional support from community resources that we could help arrange? (spouse remaining in the home, filing for Medicaid insurance, transportation to visit, stress, own declining health, etc.) _____ If yes, please explain: _____

_____

_____

How are you and the rest of the family feeling about placement of your loved one?

_____

_____

_____

_____

How can we help you during this difficult time (communication, services, etc.):

_____

_____

_____

What will be the most difficult change for your loved one? _____

_____

_____

Daily Routine:

Usual rising time: _____

Breakfast foods: _____

Lunch foods: _____

Supper foods _____

Food dislikes _____

Any chewing for swallowing problems? Yes _____ No _____
If yes, please describe: _____

Does your loved one need assistance with eating? Yes _____ No _____
If yes, describe (cueing, fewer plates, finger foods, physical assistance)
_____

Recent weight change (gain or loss): Yes _____ No _____
If yes, how much _____

Does your loved one prefer to eat alone or with someone? Alone _____ With someone _____

Usual bed time _____

Describe bedtime routine
_____

_____

Special bedtime preferences (please circle): raised edge mattress body pillow TV/Radio Fan

Does your loved one sleep alone or with someone? Alone _____ With someone _____
If with someone, who? _____

Does your loved one get up at night to use the bathroom? Yes _____ No _____ How often? _____

_____

Does your loved one use a bedside commode? Yes _____ No _____

Does your loved one have a history of constipation or loose stools? Yes _____ No _____
If yes, describe _____

If yes, what helps? _____

Does your loved one have a history of laxative use? Yes _____ No _____

Does your loved one get up at night for other reasons? Yes _____ No _____

If yes, what reason and how often? _____

Does he/she usually nap? Yes _____ No _____ If yes, when and where _____

_____

Please describe a normal day for your loved one (meal times, activities during the day, stays inside/goes outside, etc.)

_____

_____

_____

Does your loved one usually have frequent contact with family? Yes _____ No _____

Does your loved one prefer a shower _____ or bath _____ and how often _____

Favorite pet _____ Name of pet _____

Does your loved one start activities on his/her own? Yes _____ No _____ If no, how do you get your loved one involved in activities?

_____

_____

Has there been a recent change in daily routine? Yes _____ No _____ If so, please explain:

_____

_____

_____

Would your loved one like a change in activity participation? Yes _____ No _____

Does your loved one have difficulty hearing? Yes _____ No _____

Does your loved one have hearing aids? Yes _____ No _____ If yes, does your loved one wear them? Yes _____ No _____

Last hearing appointment: _____ Name of doctor: _____

Does your loved one have difficulty seeing? Yes _____ No _____

Does your loved one have prescription eyeglasses? Yes _____ No _____ If yes, does your loved one wear them? Yes _____ No _____

Eye doctor's name:_____ Date of last appointment: _____

Does your love one use any other adaptive equipment (magnifying glass, communication board, walker, cane, wheelchair, etc.)? Yes _____ No _____ If yes, when does your loved one use it?

_____

_____

Does your loved one have memory problems? Yes _____ No _____ If yes, please describe:

_____

_____

History of falls: Yes _____ No _____
If yes, explain: _____

Any emergency room visits in the last 90 days? Yes _____ No _____
If yes, explain: _____

Any hospital admissions in the last 90 days? Yes _____ No _____
If yes, explain: _____

Any history of physical discomfort or pain in any certain area? Yes _____ No _____
If yes, explain: _____

What helps: _____

What makes it worse: _____

Medicine used: _____

Non medicine techniques used (hot/cold pack, positioning, stretching, etc.):

_____

Dominant hand: Right _____ Left _____

How did your loved one take medications at home?
Time of day: _____

Whole _____ Crushed _____

Were medications mixed with anything? _____

Do you/your loved one want medications given the same way they were taken at home?
Yes _____ No _____ If not, then how? _____

Do you/your loved one wish to be awakened for medications? Yes _____ No _____

Anything else you would like us to know about your medications? _____
_____

Thank you for taking the time to complete this history. With your help we will better meet the needs of your loved one. Please feel free to talk with us at any time about any of these questions in more detail.

_____ _____
Signature of Person Completing Date

_____ _____
Social Worker Date

_____ _____
Nursing Facilitator Date

_____ _____
Activity Director/Assistant Director Date

_____ _____
Dietician/Dietary Manager Date

Medicare Secondary Payor Questionnaire

1. Is this illness/injury covered by Worker's Compensation? Yes___No___
If yes, note employer name and address and claim number, if Assigned, in #12

2. Is this illness/injury covered by the Black Lung program? Yes___No___
If yes, note where billing should be sent in #12

3. Is this patient a member of a health maintenance organization (HMO)? Yes___No___
If yes, what is the name and address of the HMO? Complete in #12

4. Is this illness/injury due to an automobile accident? Yes___No___
If yes, what is the name of automobile insurer responsible for coverage? If yes, complete information in #12

5. Does this patient feel someone else is responsible for this injury/illness? Yes___No___
Name of responsible party: _____
Name of liability insurer/attorney: _____
Address of liability insurer/attorney: _____
_____

6. Is this patient covered by an Employer Group Health Plan (EGHP) including Federal Employee Health Benefits? Yes___No___

7. Is this patient 65 years of age or older? Yes___No___
If yes, move to #8 – If no, move to #9

8. Is this patient or the patient's spouse actively employed by an employer of 20 or more employees? Yes___No___
If yes, enter the EGHP data in #12 – if no, move to #9

9. Is this patient entitled to Medicare coverage solely on the basis of a Disability? Yes___No___
If no, move to #10 – If yes, is the patient or the patient's spouse or Parent actively employed by an employer of 100 or more employees? Yes___No___
If yes, enter the Large Group Health Plan data in #12 – If no, move to #10

10. a. What is the date of the patient's retirement? _____
b. What is the date of spouse's retirement? _____

11. a. Is this patient entitled to Medicare coverage solely on the basis of End Stage Renal Disease (ESRD)? Yes___No___
If no, move to prior stay information

b. Has this patient completed the ESRD coordination period? Yes___No___
If no, enter the EGHP data in #12 – If yes, move to prior stay information

12. Name of Insurance Company or HMO:_____

Insured's name: _____

Insured's policy #:_____

Employer: _____

Address of Insurance Company or HMO: _____

PRIOR STAY INFORMATION

Has this patient been confined to a hospital or skilled care nursing facility
Within the last sixty (60) days? Yes___No___

If yes, complete the following information for ***EACH*** stay:

1. Hospital or Skilled Nursing Facility: _____
Address: _____
Admission Date: _____/_____/_____
Discharge Date: _____/_____/_____

2. Hospital or Skilled Nursing Facility: _____
Address: _____
Admission Date: _____/_____/_____
Discharge Date: _____/_____/_____

3. Hospital or Skilled Nursing Facility: _____
Address: _____
Admission Date: _____/_____/_____
Discharge Date: _____/_____/_____

THERAPY HISTORY

Has this patient received therapy in a skilled nursing facility or any other
Outpatient setting in calendar year _____? If so, list below:

1. SNF or any other outpatient program: _____
Address: _____
Dates of Therapy: _____

2. SNF or any other outpatient program: _____
Address: _____
Dates of Therapy: _____

3. SNF or any other outpatient program: _____
Address: _____
Dates of Therapy: _____

Name of person who supplied the above information: _____
Telephone #:_____( )_____
Name of the patient: _____
Date:_____/_____/_____

Do you receive Supplemental Security Income (SSI)? Yes___No___

Does It appear that the stay at this facility will be long term? Yes___No___

FOR OFFICE USE ONLY: IF THE ANSWER TO BOTH QUESTIONS IS YES, CONTACT THE SOCIAL SECURITY ADMINISTRATION PER PUBLIC LAW 103-387. (_____) CHECK IF DONE
DATE AND INITIAL: _____/_____/_____ _____