Charlevoix County Medical Care Facility
1728 South Peninsula Rd. East Jordan, MI 49727
Phone: (231) 308-9225
Fax: (231) 536-0393
Email: admissions@grandvue.org

Please complete this application and return to Grandvue Medical Care Facility in-person, fax or email at the address above. If you need assistance, please feel free to contact the Admissions Coordinator at 231-308-9225. I look forward to working with you

ADMISSION APPLICATION

APPLICANT INFORMATION	
Name:	Date of Birth:
Full Legal Name:	
Home Address:	
Mailing Address:	
Telephone #:	Alt. Phone #:
Email Address:	
County of Residence:	

INSURANCE & LEGAL INFORMATION:		
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
Will you be applying for Medicaid?		

Does the applicant have a:

- Legal Guardian
- Conservator
- Healthcare Power of Attorney
- Financial Power of Attorney
- None of the above

THIS APPLICATION IS VALID FOR 45 DAYS UPON RECEIPT

RESPONSIBLE PARTY	
Person Responsible for assisting with healthcare matters of applicant	
Name:	Relationship:
Address:	
Telephone #:	Alt. Phone #:
Email Address:	
Preferred Method of Contact: Cell Phone	Email
Person Responsible for assisting with financial matters of applicant SAME AS ABOVE ◯	
Name:	Relationship:
Address:	
Telephone #:	Alt. Phone #:
Email Address:	
Preferred Method of Contact: Cell Phone	Email

IMPORTANT NOTICE

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INCLUDE COPIES OF
GUARDIANSHIP, POWERS OF ATTORNEY, ADVANCE DIRECTIVES
AND MEDICAL/INSURANCE CARDS

****

____ ________________
Print Name **Date**

____
Signature

THIS APPLICATION IS VALID FOR 45 DAYS UPON RECEIPT

RESIDENT HISTORY

Resident Name:		
Gender:	Preferred Language:	Interpreter or assistive devices for communication needs:
Date of Birth:	Place of Birth:	Preferred Name:

1. Marital Status?
   ❒Married ❒Divorced ❒Separated ❒Widowed ❒Living Together ❒Single
2. Spouse's or significant other's name: ______________________________
3. Children's names: ______________________________
4. Important animal(s), family, friends (describe): ______________________________

   ____
5. Race: What is your race? ❒White ❒Black or African American ❒American Indian or Alaska Native
   ❒Asian Indian ❒Chinese ❒Filipino ❒Japanese ❒Korean ❒Vietnamese ❒Other Asian
   ❒Native Hawaiian ❒Guamanian or Chamorro ❒Samoan ❒Other Pacific Islander
   ❒Other (describe): ______________________________ ❒None of the Above
6. Ethnicity: Are you of Hispanic, Latino/a, or Spanish origin? ❒Yes, Mexican, Mexican American, Chicano/a
   ❒Yes, Puerto Rican ❒Yes, Cuban ❒Yes, another Hispanic, Latino/a, or Spanish origin ❒No
7. Military Service? ❒Yes ❒No Branch: ______________________ Years in service: __________
8. Active in Veteran Organizations: ______________________________
9. Religious/Spiritual preference: None ___ Religion _______________ Church______________________
10. Highest level of education completed: ______________________________
11. Occupation(s): ______________________________
12. Does the resident have a history of traumatic experience (describe)?______________________________

    ____
13. Received Mental Health Services? ________ Describe (e.g., outpatient or inpatient treatment):

    ____

14. Have the resident's behavior patterns or mood changed recently & what coping skills are helpful (describe)?

____

____

15. Does the resident have a history or recent life event that affects or impacts them (describe)?

____

____

16. Is there anything we could try not to do or say that upsets the resident (describe)?

____

____

17. Observation of resident's behavioral status: ❒Wandering ❒Resisting care ❒Hoarding/rummaging ❒Yelling out ❒No behavioral concerns identified at this time

18. Does the Resident have a history of exit seeking or going outdoors when unsafe to do so (describe)?

____

____

19. Does the resident have a history of physical or verbal behaviors (frequency, what causes the behavior, what helps, and time of day that is most difficult)? ____________________________________

____

____

20. What is anticipated to be the most challenging aspect of this move for the resident, family, friends, representatives and how can we help?____

____

21. Substance Use: ❒Tobacco products (current/past) ❒Alcohol (current/past)

❒ Other (current/past): ____

22. Is the resident registered to vote? ________ In what jurisdiction? ______________________________

23. Current Activity Interests (describe):

____

____

24. Past Activity Interests (describe):

____

____

25. Prefer Groups: __ Solitary__ Either __

26. Describe the usual daily routine (e.g., sleeps in bed or recliner, TV left on, preference of naps, mealtimes, bedtime, pajamas), with times: ____

____

____

27.Food Likes and dislikes: ____

____

28. What dining assistance works best (e.g., using fewer plates, finger foods, physical aid, modified silverware, cups, bowls), and do they have any problems with chewing or swallowing? _______________________

____

____

30. What is the resident's dominant hand? __________

31. Weight: Current _______ 6 months ago ____ 1 year ago _____ Usual adult weight ________

32. Current bowel and bladder routine and what is the frequency during the night: ______________

____

33. Bathing preference: __ shower __tub __ other (describe): ___________________________________

Frequency and time(s): ____

34. Current primary care physician and specialty providers, and when was the last visit?________________

____

35. Does the resident wish to continue with appointments with any providers? If so, which one(s)__________

____

36. Hearing: __ adequate __ impaired __ hearing aids (L/R/Both) __ Does the resident desire to continue with appointments with the audiologist? If so, what is the provider's name and location, and when was their last visit?____

37. Vision: __ adequate __ impaired __ glasses __ contacts. Does the resident desire to continue with appointments with the optometrist? If so, what is the provider's name and location, and when was their last visit?____

38. Dental (dentures, partials, implants)? ________________________ Does the resident have a current dentist, and do they wish to continue with appointments with them? If so, what is the provider's name and location, and when was their last visit?____

39. Funeral home selection: ______________________________________Prepaid funeral expenses? __________

40. Assistive devices currently in use (e.g., walker, wheelchair, shower chair, lift) and do they have any specific weakness on one side (describe): ____

____

41. History of falls in the past 6 months (describe): ____

____

42. Pain or Discomfort: Please describe the location, type, what works to alleviate, and what doesn't work or makes it worse: ____

____

43. Medications taken and assistance required (e.g., magnifying glass, communication board, reading or distance glasses): ____

44. Additional Information: ____

____

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 discuss any of these questions with us in more detail.

Completed by: ____ **Date:** ____________________________

ASSETS DECLARATION
PATIENT AND SPOUSE
Michigan Department of Health and Human Services

FOR OFFICE USE ONLY				
Beneficiary Name				
Client ID				
Case Number				
County	District	Section	Unit	Specialist

PLEASE PRINT

Patient's Name (First, Middle, Last)	Phone No. of Nursing Home		Spouse's Name (First, Middle, Last)	Spouse's Phone No.	
Address of Nursing Home (Number, Street, Rural Route)			Spouse's Address (Number, Street, Rural Route)		
City	State	Zip Code	City	State	Zip Code
Patient's Birthdate (Mo/Day/Yr)	Patient's Social Security		Spouse's Birthdate (Mo/Day/Yr	Spouse's Social Security*	

This form asks questions about the property or assets owned by you and/or your spouse. This information is needed to determine your eligibility for Healthcare Coverage and the amount of assets that can be protected for the benefit of your spouse. Answer the following questions by providing information about all assets owned by you and/or your spouse as of ________________________. Include assets you or your spouse own jointly with family or other persons.

ASSETS

1. Do you and/or your spouse have any assets (include assets held jointly)?

☐ Yes ▸ Check all types of assets your household has and complete the table ☐ No

☐ Checking/draft account
☐ Money market accounts
☐ Savings/share accounts
☐ Certificates of Deposit (CD)
☐ Christmas club accounts
☐ Patient trust fund
☐ Case on hand or in safe deposit
☐ Savings, bonds, stocks or mutual funds
☐ IRA, KEOGH, 401K or Deferred Compensation account(s)
☐ Trust or Annuity
☐ Land contract, mortgage or other notes payable to household member
☐ Real estate (including place you live)
☐ Life estate/life lease
☐ Burial plot(s), casket, etc.
☐ Tools, equipment, livestock or crops
☐ Life insurance
☐ Other Assets ___________________
☐ Health Savings Account
☐ Burial trust/funeral contract(s)

Owner(s) of asset(s)	Type(s) of Asset(s)	Balance amount of value	Name and address (bank, insurance company, etc.)	Account/policy number, etc.

AUTHORITY: 42 CFR Part 435.
COMPLETION: Voluntary.
PENALTY: No Healthcare Coverage.

The Michigan Department of Health and Human Services (MDHHS) does not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, genetic information, sex, sexual orientation, gender identity or expression, political beliefs or disability.

*Optional if the community spouse is not requesting assistance.

ASSETS

2. Does anyone in your household have any vehicles?

☐ Yes ▶ Check all types of assets your household has and complete the table ☐ No

☐ Car ☐ Truck ☐ Boat ☐ Camper/trailer ☐ Motorcycle ☐ RV ☐ Other Vehicle

Owner(s) (As shown on vehicle title or registration)	Year	Make/Model	Amount Owed

3. Has anyone in your household:

- sold or given away property, land, vehicles, stocks, bonds, savings, cash, checking, income, etc., closed any accounts or removed or added a name on any asset within the last 60 months? ☐ Yes ▶ Who: ☐ No
- filed a pending lawsuit which may bring money, property, etc.? ☐ Yes ▶ Who: ☐ No
- received a one-time cash payment (such as worker's compensation, lottery winnings, insurance settlement, lawsuit award, etc.) within the last 60 months? ☐ Yes ▶ Who: ☐ No
- or has anyone acting for any household member, ever put any money, lawsuit settlement, income or assets in a trust, annuity or similar legal device? ☐ Yes ▶ Who: ☐ No

AFFIDAVIT

I swear or affirm that all the information that I have written on this form or told to a specialist is true. I understand that I can be prosecuted for perjury if I have intentionally given false information. I also know that I may be asked to show proof of any information I have given. I also know that if I have intentionally left out any information or if I have given false information, which causes me to receive assistance I am not entitled to or more assistance than I am entitled to, I can be prosecuted for fraud.

Estate Recovery. I understand that upon my death the Michigan Department of Health and Human Services (MDHHS) has the legal right to seek recovery from my estate for services paid by Healthcare Coverage. This means that some or all of my estate may be recovered. MDHHS will not seek to recover against the estate while there is a legal surviving spouse or a legal surviving child who is under the age of 21, blind, or disabled. An estate consists of real and personal property. If you have received an asset disregard due to a long-term care partnership policy, Estate Recovery applies to all assets whether they are subject to probate administration or not. Estate recovery only applies to certain Healthcare Coverage recipients who received Healthcare Coverage services after the effective date of the estate recovery statute. MDHHS may agree not to pursue recovery if an undue hardship exists. An application must be submitted to determine if the applicant qualifies for an undue hardship waiver. Undue hardship waivers are temporary. For further information regarding Estate Recovery, call 800-642-3195.

Signature (Patient or Representative)		Date (Month, Day, Year)
Two Witnesses Only If Signed by Mark X	Signature of First Witness	Signature of Second Witness

NOTE: If you signed this application on behalf of someone else, complete the information below.

Name (First, Middle, Last)	Phone Number	Relationship to Patient	
Street Address	City	State	Zip Code

Patient: ____________________________ DOB: ______________

☑ Physician Checklist for Admission Application

In accordance with state and federal guidelines for skilled nursing facility admission, please provide the following documentation. Applications are reviewed once all required documentation has been received.

☐ **Medical History & Physical**	Updated in the past 30 days
☐ **Lab & Diagnostic Reports**	All results from the past 12 months
☐ **Signed Physician Orders**	Include: 1) Statement of need for 24-hour care. 2) Diagnoses, including dementia Diagnosis, if appropriate. 3) Current medications, diet, treatments, Allergies, etc.
☐ **Immunization Records**	
☐ **Screening Form DCH 3877/3878**	OBRA Federal law mandates completion of these forms before admission.
☐ **Physician Statement(s) Re: Decision-Making Capacity**	**Only if indicated *(see below)**

Patients' Rights Michigan Act 312 December 18, 1990
Subsection (8)-Requirement:

The patient's inability to make medical decisions must be determined by the patient's attending physician and another physician or licensed psychologist.

The law requires that the physician or psychologist document the determination in writing, include the written determination in the patient's medical record, and review the determination at least annually.

Grandvue Fax: 231-536-0393