Mason County's Oakview MEDICAL CARE FACILITY

ADMISSIONS APPLICATION

INSTRUCTIONS / INFORMATION

General

Oakview's receipt of this application does not guarantee placement, however, it confirms that the applicant's information has been received for admission review and an Oakview staff member will be in touch with you regarding our waiting list and admission procedure. Thank you in advance for your interest, input and cooperation.

Pre-Admission Screening

A pre-admission screening is required by Federal OBRA Regulations for individuals seeking residents in a nursing facility who have a serious mental illness or a developmental disability. The applicant's primary care physician will need to assist with completing the necessary pre-admission screening paperwork (commonly referred to as PASARR or Forms 3877 and 3878). Time delays are to be expected if it is determined that a full Level II Assessment is needed.

Chest X-Rays

A chest x-ray must only be completed 90 days or less prior to the date of admission to a skilled nursing facility if the resident is a known positive reactor for tuberculosis. If an x-ray is needed and this has not already been done, you will need to contact your physician regarding this matter.

Non-Smoking Facility

Oakview Medical Care Facility, including the Sutter Living Center, is a non-smoking facility.

Application Submission

Please complete this application and return to Oakview

By Mail: Attn: Admissions
Oakview Medical Care Facility
1001 Diana Street
Ludington, MI 49431

or

By Fax: 231-843-7899

Contact Information

If you have questions regarding the completion of this form, please contact our Admissions office at: 231-845-5185 ext. 227.

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PLEASE PRINT / TYPE AND COMPLETE PAGES 2 - 4 IN FULL

PART A. Applicant Personal Information

Applicant's Full Name (Last, First, MI)			Date
Social Security #	Birth Date		Age
Legal Address (Street / Box Number)			Phone
City	State	Zip	County

Nationality (Please check one)	☐ Citizen of United States
	☐ Other (Please List)
	Date of entry into United States, if applicable
	If alien, Registration #

Currently staying at (Please check one)	☐ Adult Foster Care	☐ Nursing Home
	☐ Home	☐ Psychiatric Facility
	☐ Hospital	☐ Substance Abuse Facility
	☐ Other (Please List)	

PART B. Applicant Background

Birthplace

City	State	Zip	Country

Military

Is Applicant a Veteran?	☐ Yes	☐ No
Is Spouse a Veteran?	☐ Yes	☐ No

Service Number	V.A. File Number

PART C. Legal Information

Does Applicant have any of the following? (Please check all that apply and ***send or attach copies***)	☐ Court Appointed Conservator ☐ Court Appointed Guardian ☐ Financial DPOA ☐ Health Care DPOA ☐ Living Will ☐ Other Written Advance Directives (regarding life support issues)

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PART D. Medical Information			
Current Primary Care Physician Name			Phone Number
Date of last hospital admission	Name of hospital		
Ever been admitted to a Nursing Home? ☐ Yes ☐ No			
Name of Nursing Home			Contact Number
Is the prospective resident aware of this application? ☐ Yes ☐ No			
Does the prospective resident use tobacco products? ☐ Yes ☐ No			
If yes, is applicant agreeable to quitting? ☐ Yes ☐ No			
Is resident a known positive reactor for tuberculosis? ☐ Yes ☐ No			
If yes, date of last chest x-ray			
Current Diagnoses (Please list. If applicant has a Dementia diagnosis, indicate diagnosing physician.)			
Current Medications & Dosages (If necessary, please write additional medications on a separate page)			
Known Allergies (Please list)			
Does applicant currently have or receive the following? (Please check all that apply)	☐ Dialysis ☐ Hospice Services ☐ Tracheotomy	☐ Ventilator or Respirator ☐ Wound Care	
Any current evidence or history of? (Please check all that apply)	☐ Behavioral Problems / Issues ☐ Confusion ☐ Dementia or Alzheimer's Dementia ☐ Developmental Disability / Mental Retardation ☐ Hallucinations / Paranoia ☐ Mental Illness ☐ Substance Abuse		
If you checked any of the above, please give a brief explanation:			

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PART E. Insurance Information			
IMPORTANT: Please attach copies of ALL INSURANCE CARDS (front and back)			
Medicare / Medicaid			
Please check any of the following that the applicant currently receives:			
☐ Medicaid	Medicaid Number		
☐ Medicare Part A	Card Date	Medicare Number	
☐ Medicare Part B	Card Date		
☐ Medicare Part D	Prescription Plan Name	Prescription Plan Number	
☐ SSI Recipient			
☐ Veteran's Benefits	Please list		
Have you, or will you be, applying for Michigan Medicaid?	☐ Yes ☐ No		
If yes, please list date applied:			
Other Insurance			
Type of Insurance		Name listed on Insurance Card	
State	Contract Number	Group Number	Service Code
Insurance Company's Address (Street / Box Number)			
City		State	Zip

PART F. Contact Persons		
1.	First and Last Name	Home Phone
	Email Address	Cell Phone
2.	First and Last Name	Home Phone
	Email Address	Cell Phone
Name of person submitting application		Relationship to prospective resident

For Admissions Office Use Only			
Recommended Placement	☐ **O M C F** **Skilled Nursing Unit**	☐ **S L C** **Alzheimer's/Dementia Unit**	☐ **Unknown**