Mason County's Oakview MEDICAL CARE FACILITY

SUPPLEMENTAL FINANCIAL ADMISSION INFORMATION

PRIVATE RATE

$327.00 for room and board; applicable charges per visit for physician services; plus ancillary/supplemental charges (includes medications, x-rays, specialized rehabilitation therapy, etc.). This rate is subject to change depending on costs of operation. Once admitted you will be informed of a rate change at least 30 days before it becomes effective. Individuals who are private pay will be charged for one month's worth of services in advance.

MEDICARE PART A

1. Must have a Medicare Claim Card.
2. Must be skilled care, which requires services by licensed personnel (as determined based on Medicare criteria).
3. Must have been in a hospital (acute care) for 3 consecutive days or longer.
4. Must be admitted to Oakview Medical Care Facility within 30 days of discharge from the hospital.
5. Medicare A coverage is a maximum or 100 days. The first 20 days may be paid in full by Medicare A, if eligibility requirements continue to be met. The next 80 days Medicare A only pays a portion of the cost. What Medicare A does not pay under the Medical Assistance Program (whereby a patient pay amount is determined by the Department of Health & Human Services), this amount must be paid before Medicaid will pay its share for services provided.
6. A Resident may be denied or rejected by Medicare at any time from day 1 to day 100.

MEDICAID

If unable to pay as a private pay Resident, it is advisable that you immediately apply for the Medical Assistance Program at the following address and telephone number:

Mason County Department of Health & Human Services
915 Diana Street
Ludington, Michigan 49431
Telephone: (231) 845-7391

OAKVIEW CONTACT

Mason County's Oakview MEDICAL CARE FACILITY

1001 Diana Street
Ludington, MI 49431
www.oakviewmcf.com

SUSAN RAZMINAS
Reimbursement Specialist
231-845-5185 (x222)
SRazminas@oakviewmcf.com

Mason County's Oakview MEDICAL CARE FACILITY

RESIDENT ADMISSION / TRANSFER INFORMATION

Name	DOB / /	Age

Sex: ☐ M ☐ F	MS: ☐ S ☐ M ☐ D ☐ W	Religion:	SS#: - -

Address:	C:	ST:	ZIP:
Contact:	H:	W:	
Guardian:	H:	W:	
MDPOA:	H:	W:	
Transfer from:	DOH: / /		
Transfer to: **OAKVIEW MEDICAL CARE FACILITY**	DOT: / /		
Medicare #:	Medicaid:		
Commercial:	Policy #:		

ASSESSMENT

Reason for transfer

Vital Signs	T:	P:	BP:	WT:	HT:
Allergies:			Food Allergies:		

Speech	☐ Normal ☐ Impaired ☐ Aphasic
Hearing	☐ Normal ☐ Deaf ☐ HOH ☐ Aides ☐ Rt ☐ Lt
Sight	☐ Normal ☐ Impaired ☐ Blind ☐ Glasses ☐ Contacts
Mental Status	☐ Alert ☐ Oriented (Self: Time: Place:) ☐ Forgetful ☐ Dementia
Feeding	☐ Independent ☐ Setup/Assist ☐ Feed ☐ Tube (NG: JT:)
Dressing	☐ Independent ☐ Assist ☐ Total Assist
Bathing	☐ Independent ☐ Assist ☐ Total Assist
Bladder	☐ Continent ☐ Incontinent ☐ Catheter ☐ Inserted ☐ D/C
Bowel	☐ Continent ☐ Incontinent ☐ Colostomy (Date of last BM:)
Activity	☐ Ambulate ☐ Indep ☐ Assist ☐ (1) ☐ (2) ☐ SCB ☐ BSC ☐ BRP ☐ Chair
Assistive Devices	☐ Walker ☐ Cane ☐ Crutches ☐ W/C ☐ Braces ☐ Prosthesis
Pace Maker	☐ Yes ☐ No
Skin Integrity	☐ Intact ☐ Open Area Stage: ☐ I ☐ II ☐ III ☐ IV
	Location/Size of Wound:
	Areas of Bruising:

Physician or Nurse's Signature	**Date**

Mason County's Oakview MEDICAL CARE FACILITY

PHYSICIAN ORDERS

Patient Name	
Diagnosis	
Surgical Procedure(s) and Date(s)	
Admit patient to: **OAKVIEW MEDICAL CARE FACILITY**	
Informed of total health status: Patient ☐YES ☐NO Family ☐YES ☐NO	
Patient Cognition	Capable of signing documents and adequately communicating understanding of Rights & Responsibilities: ☐YES ☐NO If NO, state reasons: _____
Infection or Communicable Disease	Evidence of ☐YES ☐NO Reason: _____
Rehabilitation	☐ PT ☐OT ☐ Speech Potential to return to prior level of function: ☐GOOD ☐FAIR ☐POOR
Diet Orders	Was patient on any special diet or diet textures in last 7 days? ☐YES ☐NO If YES, explain: _____ Current Diet Orders: ☐Regular ☐ Mechanical Soft ☐Pureed ☐Carb Controlled ☐Other: _____
	Was patient on feeding tube/TPN/IV in last 7 days? ☐YES ☐NO If YES, explain: _____
Activity Level	☐Ambulate ☐Independent ☐Assist ☐ (1) ☐ (2) ☐SCB ☐BSC ☐BRP ☐Chair
Elimination	Bladder Train ☐YES ☐NO ☐Catheter Inserted FR#: _____ Bowel Enema ☐Fleets ☐Supp. Dulcolax ☐Per Facility protocol
Colostomy	
Personal Hygiene	☐Bed Bath ☐Tub ☐Shower
Respiratory	☐Oxygen TX: _____

Mason County's Oakview MEDICAL CARE FACILITY

PHYSICIAN ORDERS

Patient Name:	
TB	May have TB skin test ☐YES ☐NO If NO, indicate reason: _____ Previously treated for TB ☐YES ☐NO Xray evidence of inactive TB: _____ Known positive TB skin test: _____ Other: _____
Flu Vaccine	May have flu vaccine during season ☐YES ☐NO
Pneumovax	May have pneumovax vaccine ☐YES ☐NO Vaccine previously given: _____
Med Pass	May go out on pass with medications ☐YES ☐NO
Activities	May participate in Activities per Activity Plan of Care ☐YES ☐NO ☐N/A
Physician	Who will follow upon transfer?
Labs	
Xrays	
Medication List	☐ List including dose, route, frequency & Dx printed and attached; OR ☐ List completed below

Medication	Dose	Route	Frequency	Dx for Medication

Additional Orders

Physician's Signature	**Date**

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CLINICAL HISTORY & PHYSICAL EXAMINATION

A Clinical History and Physical Examination must be current within 48 hours following admission or 72 hours in the case of a Friday admission. If the physician completes this form **and** submits the last History and Physical that was completed, this completed form will suffice as a current and up-to-date History and Physical Examination.

Patient Name	
History	
Vital Signs	
Eyes	
Nose / Throat	
Neck	
Lungs	
Breasts	
Heart	
Abdomen	
Rectal	
Neuromuscular	
Bones and Joints	
Lymph Glands	
Skin	

Physician Signature	Date

Mason County's Oakview MEDICAL CARE FACILITY

MISSION & CRITERIA ACKNOWLEDGEMENT

Oakview Medical Care Facility's
SUTTER LIVING CENTER
Alzheimer's Special Needs Unit

MISSION

The mission of Oakview's Alzheimer's Unit, The Sutter Living Center (SLC) is to provide holistic care to those residents afflicted with Alzheimer's disease or related conditions by providing a safe environment where residents will be able to function at their optimal level while being a part of their living environment. This care will not only focus on the resident's physical health but also their emotional and psychosocial needs.

CRITERIA

The SLC is a transitional unit; residents must meet specific criteria for admission and will be discharged with an irreversible decline in condition.

ACKNOWLEDGMENT

I have read the above statements and understand the Mission and Criteria of the SLC. I also understand that there may come a time when my loved one no longer meets these criteria and will need to be transitioned out of the SLC and into Oakview's skilled nursing unit.

Resident's Responsible Party Signature	Date
Witness Signature	Date