Dobie Road
INGHAM COUNTY MEDICAL CARE
Dedicated to Improving Lives.

3860 Dobie Road
Okemos, MI 48864
Phone: 517-381-6130
Fax: 517-381-6014

IMPORTANT INFORMATION FOR THOSE APPLYING FOR ADMISSION

Dear Applicant:

Thank you for your interest in Ingham County Medical Care also known as "Dobie Road". We look forward to the opportunity to meet the needs of your family.

In order to place someone on our waiting list, the attached application must be completed and returned to the Admissions Office.

It is the responsibility of the potential resident or family member to call the Admissions Office every two months to keep us informed of the applicant's continued interest in placement. Please be prepared to give a brief update on condition and status at the time of the phone call.

Please note this is a *non-smoking facility.* Individuals who currently smoke won't be able to be considered for admission.

Submission of an application does not guarantee admission. Due to care needs and staffing requirements, Dobie Road may not be able to admit applicants from the waiting list in the exact order received.

Also please note that the application for admission is not complete until all paperwork is received, including forms that are needed from the physician. Complete admission packets are needed before we are able to add applicants to our waiting list.

If you have any questions, please contact the Admissions Team at 517.381.6130.

Sincerely,

Dobie Road Admissions

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ADMISSION APPLICATION PACKET

PLEASE READ CAREFULLY

The following information must be completed and returned to the Admissions Office in order to place one's name on our waiting list. The application packet must be returned COMPLETED (including physician forms). Please follow up with the physician completing forms to ensure they have been sent as incomplete application packets are unable to be processed. You should make a copy for your files before submitting it to us.

_____ Applicant Profile	This form is in the packet and may be completed by **applicant or family** (a visiting nurse or foster care home caregiver may also complete this form).
_____ Applicant Financial Information	This form is in the packet and may be completed by **applicant or family**.
_____ History and Physical (H&P) **	This form is in the packet and must be completed by a **physician**. It may be computer generated from the physician's office. If the applicant is hospitalized within 30 days of applying, an H&P record may be obtained from the hospital medical records and is acceptable.
_____ DCH-3877 & DCH-3878 Forms	These forms are completed by the **physician** and are required for admission to a nursing home.
_____ Certification for Decision Making Form	This form is in the packet and must be completed by a **physician**.

_____ Copies of Health Insurance Cards, Social Security, Medicare, and Medicaid Cards

_____ Copies of Durable Power of Attorney, Guardianship, and/or Conservatorship Documents, if any.

** Please note: if the applicant already resides in a skilled nursing facility, the above required information may be taken from the applicant's chart and submitted from that facility's files and documentation.

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Admission Application

Applicant's Name _____ Date _____

Gender _____ Date of Birth_____ Age _____ Marital Status _____ Race/Ethnicity_____

Religious Preference _____ Citizenship _____

Primary Language _____ English Speaking Ability: Good _____ Fair _____ Poor _____

Occupation history_____ Education Level _____

Military Veteran/Branch _____

SS# _____ Medicare # _____Date for Medicare A_____ Medicare B_____

Other Insurance Name _____ Policy # _____

Medical Responsible Party Name/Relationship_____

Address _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Financial Responsible Party Name/Relationship _____

Address _____

Home Phone # _____ Cell Phone # _____ Work Phone # _____

Other Family/Contact _____ Phone # _____

Other Family/Contact _____ Phone # _____

Other Family/Contact _____ Phone # _____

Primary Care Physician Name _____

Office # _____Fax # _____

Hospital Preference: McLaren _____ Sparrow _____

*It is important that we have all necessary information regarding your loved one in order to provide the best care possible. By having your loved one's preferred funeral home on record, we can avoid undue stress for you during a difficult and already stressful time. You are not required to pre-pay or make arrangements at this time, we just ask that we have the preferred funeral home listed on your loved one's application.

Funeral Home Preference _____ Office # _____

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Applicant Profile

Applicant's Name _____ Date _____

1. Has applicant recently been hospitalized? _____ If yes, where _____
   Admission Date _____ Reason _____
2. Has applicant ever been admitted to another nursing home? _____
   If yes, where? _____ Dates _____
   Reason _____
3. What are applicant's current living arrangements?

   _____
4. Why does the applicant desire to come here?

   _____
5. When is placement needed? _____
6. Please list current Medications:

   _____
   _____
   _____
7. Mental Status. Is applicant alert? _____ Oriented to self? _____
   Oriented to place? _____ Oriented to time? _____
   Is applicant forgetful? _____ Confused? _____
   Refuse care? _____ Refuse Medications? _____
8. Does applicant have mood and/or behaviors which are disruptive or interfere with his/her ability to accept care? _____ If yes, please explain. _____

   _____
9. Mobility. Does applicant walk independently? _____ Need assistance? _____
   Use walker? _____ Use wheelchair? _____ Bedridden? _____
10. Has applicant fallen in the past 3 months? _____ If yes, please explain circumstances.

    _____
11. Can applicant feed him/herself? _____ Need complete or partial assistance to eat? _____
    Tube Fed? _____ Current Weight _____ Height _____ Recent weight changes _____
12. Continence. Is applicant continent of bladder? _____ Continent of bowel? _____
    Does applicant wear adult briefs? _____
13. Skin condition. Fragile? _____ Skin tears? _____ Rashes? _____ Don't know _____
    Does applicant have bedsores? _____ If so, location and treatment _____

    _____

14. Does applicant have normal sleeping habits? _____ Please explain sleeping routine _____

_____

15. Are any safety precautions necessary?_____ If yes, please explain

_____

_____

16. Does applicant use any of the following? : Oxygen _____ if yes, amount _____
Cane? _____Wheelchair? _____ Walker? _____ Glasses? _____
Hearing aids? _____ Dentures? _____ Other _____

17. What does applicant like to do? _____

_____

18. Does applicant smoke? _____ Drink alcohol? _____

19. Other pertinent information _____

_____

_____

Consent For Release of Information

Name _____ Date _____

I hereby give consent for _____
to release information from my medical record to the following: Ingham County Medical Care Facility

_____ / _____

Signature of Applicant Signature of DPOA/Guardian/ Responsible Party

Name of person completing form: _____ Relationship _____

Home # _____ Cell # _____ Office # _____

Signature _____ Date _____

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Applicant Financial Information

Please know that we understand the sensitive and personal nature of the information requested in this application. We will keep your information confidential and use it to for purposes to determine eligibility for admission.

Applicant's Name _____ Date _____

Permanent Address _____ City/State _____ Zip _____

Current Living Address _____ City/State _____ Zip _____

Birth Date _____ Social Security Number _____

Medicare # _____ Effective Date Part A _____ Part B _____

Other Insurance Name _____ Policy # _____

Prescription Coverage _____ Company _____ Policy # _____

Dental Insurance _____ Company _____ Policy # _____

Vision Insurance _____ Company _____ Policy # _____

Does applicant have a court appointed guardian? _____ Conservator? _____

If yes, list name and relationship _____

Date guardianship/conservatorship established _____

Has applicant named a power of attorney for medical decisions? _____

If yes, list name and relationship _____

Has applicant named a power of attorney for financial matters? _____

If yes, list name and relationship _____

Is applicant eligible for Veteran's benefits? _____ If yes, branch and Veteran # _____

Legal documentation must be provided for those listed above

Please list any skilled nursing facility applicant has used in the past 2 years:

Name _____ Dates _____

Address _____

Phone _____ Outstanding payments owed _____

Name _____ Dates _____

Address _____

Applicant Financial Information

Applicant's Name _____ Date _____

Is applicant a US citizen? _____ If no, country of citizenship _____ Resident Alien # _____

What will be the sources of the applicant's payment? Private Pay _____ Medicaid _____
Medicare _____ Long Term Insurance _____ Other Insurance _____

If private pay, list the total amount of assets available for payment: $ _____

How long does applicant anticipate being private pay? _____

Will applicant receive financial assistance from a private source? _____

If yes, who will provide the assistance? Name _____

Address _____

Phone # _____

Please provide copies of Social Security, Medicare, Medicaid, and any other Health Insurance Cards

Assets:

Does applicant own a home? _____ If yes, value? $_____

A car? _____

Please list sources of income:

Monthly Social Security/Retirement $ _____ Pension $ _____

Savings/CD's $ _____ Annuities $ _____

Settlement/Trust $ _____ Property $ _____

Interest $ _____ Trust $ _____

Rental Property/Land Contract $ _____ Other Income $ _____

Please list names & addresses of banks & credit union — Types of Account/Current Value

1. _____ _____
2. _____ _____

Life Insurance:

Please list all life insurance policies company & policy # — Cash Value

1. _____ _____
2. _____ _____

Have Funeral Home arrangements been made? _____ If yes, with whom? _____

Amount pre-paid $ _____ Amount in annuities/insurance $ _____