Cordova Community Medical Center
Nursing Home

PRE – ADMISSION QUESTIONNAIRE

The purpose of this questionnaire is to acquire as much pre-information about you or your applicant as possible. This information will aid us in providing the proper care, or ensure continuity of care, once you/he or she joins our community.

The information you enter below will be held in the strictest of confidence by this facility and the employees therein.

Applicant's Personal Information:

Applicant's Name:____ SSN: _________________

Medicare #_______________________________ Check all that apply: O Part A O Part B

Gender: O Male O Female Birth date:_________________________ Age: _______

Citizenship:_____________________ Religion: ____

Please Select One: O Single O Married O Widowed O Separated O Divorced

Level of Education: ____

Former Occupation(s): ____

Primary Room and Board Payment Source:

*(**Note**: Please be sure to complete the financial information section at the end of this application and include a copy of all cards with this questionnaire.)*

Medicaid: O Yes O No O Pending If pending, date of application: _________________

*If **Yes** or **Pending**, please provide the name and Phone number of the Case Worker:*

Name: ____ *Phone:* _________________

If **Yes**, effective date: _________________________ Medicaid #: _______________________

If **No**, will applicant be paying privately for more than 6 months? O Yes O No

If **No**, will applicant be assessing Medicare for a Skilled stay? O Yes O No

If **Yes**, please give the reason a Skilled stay is required. (Note, Skilled admissions require medical documentation and assessment to be considered.) ______________

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If **Yes**, will the applicant be returning to home after the skilled stay? O Yes O No

If **No,** will applicant be seeking future ICF (long-term care) Placement? O Yes O No

Medicare Part D Prescription Plan? O Yes O No

If **Yes**, Medicare Part D Plan Name and # ____

Advance Directives: *Check all that apply. If checked, enter date initiated.*
(***Note***: *Please provide copies of all documentation for Advance Directives.)*

O Living Will Initiated: ___________________________________

O Do Not Resuscitate Initiated: ___________________________________

O Do Not Perform CPR Initiated: ___________________________________

Funeral Arrangements:
(***Note***: *Please provide a copy of the supporting documentation for funeral arrangements.)*

Pre-Paid Funeral: O Yes O No If **Yes**, funeral home's name, address and phone number:

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Prior Residence(s):
Please check off all the places the applicant has lived in the last 60 days and list names of facilities and contact people if applicable. *If applicant has resided at home, please provide the names of relatives/care givers that assisted with care.*

O Home or Apartment O Assisted Living O Group Home O Nursing Home O Other

Home Address, if applicable:

Street: ____

City, State, Zip: ____________________________________

Home Phone: _________________ Work Phone: ________________

Other Phone: _____________________________________

Contact Person: ___________________________________

Care Giver(s): ____________________________________

Name of Facility, if applicable: _______________________________

Contact Person: _____________________________________

Phone: ________________ Fax: ________________ Other Phone: _______________

Date Admitted: _____________________________________

Name of Facility, if applicable: _______________________________

Contact Person: _____________________________________

Phone: ________________ Fax: ________________ Other Phone: _______________

Date Admitted: _____________________________________

*** **Note:** Please use a copy of the Medical Release Form, included with this questionnaire, and obtain any medical records for this applicant. Please return them with this form or have them faxed: ATTN Nursing Department, at the Fax number below.

Responsible Party Information:

*(**Note**: Please include a copy of all legal documents which designate your status. If there are Co-Guardians, Co-DPOA's, or Co-POA's, please enter their information on the back of this page.)*

Name: ______________________________ Relationship to Applicant: ______________________

Street Address: ____

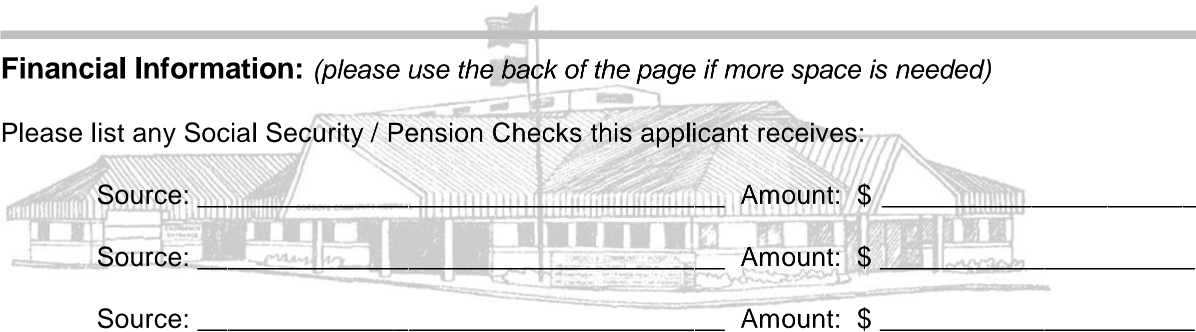
City, State, Zip: ____

Primary Phone: ___________________ Alternate Phone: __________________

Contact Person: ___________________________________

Select all that apply: O POA O DPOA Health O DPOA Financial O Guardian

Financial Information: *(please use the back of the page if more space is needed)*



Please list any Social Security / Pension Checks this applicant receives:

Source: ___________________________________ Amount: $ _____________________

Source: ___________________________________ Amount: $ _____________________

Source: ___________________________________ Amount: $ _____________________

Please list any other financial resources that this applicant has solely or jointly:

(Examples: Bank accounts, CD's, other investments, value of home(s) /property/ other assets.)

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Social Habits:

At CCMC, we provide individualized activities for all our residents. The information you provide will aid us in achieving that goal and maintaining your loved one's social well-being.

Please list any organizations applicant is currently involved in or has been in the past:

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____

Please select and add any games/activities the applicant enjoys:

O Bingo O Knitting O Singing O Ceramics O Gardening O Reading O Movies
O Painting O Piano O Arts/Crafts O Cards O Puzzles O Bowling O Television O Music

More: ____

____

Emotional Status:

At CCMC, the safety and well being of all our residents is a priority. It is essential that our Medical staff know of any diagnosis of Psychosis or Dementia which might be prevalent so we can begin and maintain a Care Plan which will ensure the safety and well being of your Applicant and all the Residents who reside at Cordova Community Medical Center, once your applicant becomes a part of our family.

Are there any emotional or Psychological issues? O Yes O No

Current Issues:

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____

Past Issues:

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Please check all that apply:

O Depression O Anxiety O Physical Aggression O Delusions O Paranoia O Verbal Aggression O Auditory Hallucinations O Visual Hallucinations O Mood Swings

Please enter any not listed here. Please explain all checked or listed items: _______________

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Is there a mood or behavior change over the course of the Day? O Yes O No

If **Yes**, please explain: ____

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Is there a Diagnosis of Alzheiner's? O Yes O No

Is there a Diagnosis of Dementia? O Yes O No

If **Yes**, what type?: ____

Please us the Medical Release form included with this Application to acquire any Medical Documents which explain any and all Diagnosis. This will allow us to provide continued and proper medical care upon the admission of this Applicant.

Other Information or Comments:

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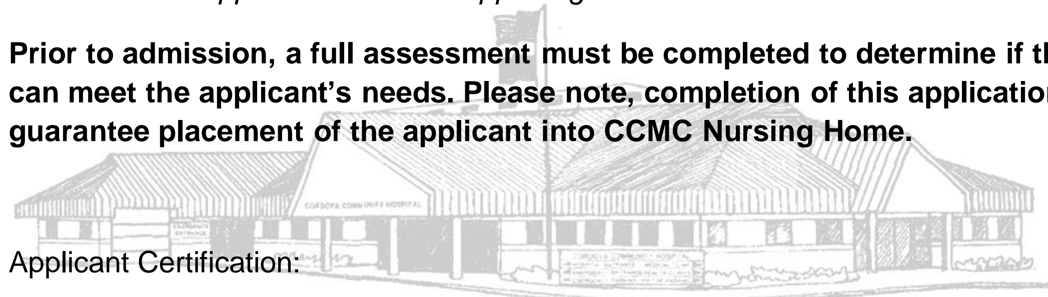
Statement:

A Medical Release form is included as part of this application. You can duplicate it as many times as you need. Please fill it out and give it to any and all professionals, be it facilities or persons, who have treated this applicant.

To ensure continuity of care, please include all supporting documentation identified throughout this questionnaire. ***Without supporting documentation, treatments and procedures cannot be initiated; therefore, your applicant will not be considered. This application will not be deemed complete until all the required documentation and information is in place****. A checklist is included with this questionnaire.*

Once a completed application is submitted to CCMC Nursing home, a staff representative will review the application and all supporting documentation.

Prior to admission, a full assessment must be completed to determine if the facility can meet the applicant's needs. Please note, completion of this application does not guarantee placement of the applicant into CCMC Nursing Home.



Applicant Certification:

I certify the information provided in or attached to this application is complete, accurate and up-to-date as of the date specified below. I further certify that there are no willful misrepresentations of the above statements and the answer to the questions herein, and that I have made no omissions of material fact with respect to any of my answers to the questions presented. I understand that if an investigation should disclose such misrepresentations or omissions, my application on behalf of my family member or myself may be rejected. Finally, I understand that if a bed offer is made and accepted and an investigation reveals I have provided false or misleading information, the bed offer may be rescinded or the facility may issue a Notice of Transfer/Discharge.

Signature of Applicant/Legal Representative Date