METHODIST VILLAGE
SENIOR LIVING

Pre-Admission Application

Date: _____ Payor Source: Private _____ Medicaid _____ Medicare _____

Applicant Name: _____
Last First MI Maiden

Preferred Name: _____

Address: _____
Street City State Zip

Date of Birth: _____ Male: _____ Female: _____
Month/Day/Year

Birth Place: _____ Mother's Maiden Name: _____

Military Service: _____ Citizen of: _____

Medicare Number: _____ Part D Plan: _____

Medicaid Number: _____ Social Security Number: _____

Other Insurance: _____

Former Occupation/Trade: _____

Marital Status: Never Married: _____ Married: _____ Widowed: _____ Divorced: _____

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Responsible Party: _____
Name Relationship to Applicant

Address: _____
Street City State Zip

Phone/Cell: _____

Attending Physician: _____ Other physicians? _____

Optometrist Name: _____ Dentist Name: _____

Church Membership: _____ Pastor: _____

Hospital Preference: _____

MVSL Room Preference: Private: _____ Shared: (Double occupancy) _____

Children/Next of Kin/Emergency Contacts:

Name: _____ Relationship to Applicant: _____

Address: _____
Street City State Zip

E-mail Address: _____ Phone/Cell: _____

Name: _____ Relationship to Applicant: _____

Address: _____
Street City State Zip

E-mail Address: _____ Phone/Cell: _____

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Name: _____ Relationship to Applicant: _____

Address: _____
Street City State Zip

E-mail Address: _____ Phone/Cell: _____

Pharmacy Preference: _____

Funeral Home: _____

Laundry Preference: (Facility or Family): _____

Does Applicant have a Living Will? _____ (If so, please attach a copy to this application).

Does Applicant have a designated Power of Attorney? _____ If so, please provide a copy.

Admitted from:
_____

How did you hear about Methodist Village Senior Living? (Circle any that apply)

1) Friend / Family
2) Physician / Physician's office / Hospital
3) Magazine - (Entertainment Fort Smith - Do South – Sparks Premier)
4) Online (methodistvillage.com / YouTube / Facebook
5) Newspaper
6) Other _____

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It is specifically understood that neither I, as a resident of MVSL, nor any member of my family, will attempt to hold MVSL responsible for injuries resulting from slips or falls that may occur in any part of the building or on any part of the grounds of the home.

Slips and falls are a potential hazard to all people in their home or elsewhere. This hazard is greater for older people and, in recognition of this fact; every possible precaution has been taken in the construction of this building to reduce this hazard. However, it must be understood and accepted by the resident and the family that the hazard cannot be completely eliminated.

It is also understood that MVSL cannot be responsible for the loss of valuables. This facility encourages the residents not to bring valuables with them but does provide a safe place for funds to be held. All due precautions are taken to safeguard the possessions of residents, but due to the nature of the facility, MVSL cannot assume responsibility for the valuables in possession of the residents unless left in the office of the facility.

I further understand that I will enter MVSL on a probationary basis. This will give me the opportunity to see if communal living is what my condition requires.

In the event applicant is unable to remain at MVSL because of any condition for which MVSL is unable to give proper care; because the applicant does not fit into group living from a psychological standpoint; or for any other reason causing the director of MVSL to feel the applicant cannot be permitted to remain, I as the responsible party assume full responsibility for removing the applicant upon notice from the President of the Board of Directors.

_____ _____

Signature – Responsible Party **Date**

_____ _____

Signature – Responsible Party **Date**

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Authorization for Examination of Medical Information:

Date: _____

Patient's Name: _____

Date of Birth: _____

Social Security Number: _____

I, hereby, authorize, MVSL to review my medical records for possible facility placement and to obtain by fax, Medical Records pertinent to my admission.

_____
Signature of Resident or Responsible Party

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Estimated Medicaid Liability Worksheet:

Resident: _____ Date: _____

Income:

1. Income (Social Security, Retirement, etc.):

   a) _____
   b) _____
   c) _____
   d) _____

Total Income: _____

2. Personal Allowance: _____40.00

   Insurance: _____

   Other: _____

Total Expenses: _____

Estimated Liability: _____

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A resident's estimated Medicaid liability shows what the resident's family is expected to pay each month from the resident's resources while the resident is on pending status for Medicaid. Liability is the part of the room cost Medicaid does NOT cover. It MUST be paid by the resident/responsible party out of the resident's resources. Once Medicaid is approved, the Medicaid office will set the official liability for the resident. This amount must be paid each month by the 10th as long as the resident is living in this facility. If the responsible party fails to complete the Medicaid process, or if the resident is turned down by Medicaid for any reason, the charges will be flipped to private pay until the balance is paid in full. It is the responsible party's task to keep up with the Medicaid process and to get all required information in a timely manner.

THE RESIDENT'S PRORATED LIABILITY MUST BE PAID UPON ADMISSION TO THE FACILITY OR THE RESIDENT WILL NOT BE ACCEPTED TO STAY AT THIS FACILITY. If you have any questions regarding the Medicaid liability, or the Medicaid process itself, feel free to speak to the Admissions Coordinator before the admission process begins.

_____

Signature of Resident or Responsible Party

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ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
Arkansas Pre-Admission Screening
Mental Illness/Mental Retardation - Level I Identification Screen

Section I **Applicant Information**

Name _____
Last First Middle

Home Address _____

_____

Phone Number ( )

DOB _____

Medicaid Number _____

Applicant's Current Location:

☐ Home ☐ Hospital ☐ Nursing Home

Other (specify) _____

Guardian/Responsible Party/Next of Kin

Name _____

Address _____

_____ Zip _____

Phone Number ( )

Person Completing ID Screen

Date DMS-787 Completed: _____

Name _____

Employer _____

Address _____

_____

Phone ( )

Comments: _____

_____

_____

_____

COMPLETE BOTH SECTIONS, BOTH SIDES

Section II

Mental Retardation/Developmental Disability

1. Does the individual have a diagnosis or history of mental retardation or a related condition? ☐ Yes ☐ No

   If yes, specify diagnosis/es
   ☐ Mental Retardation ☐ Autism
   ☐ Cerebral Palsy ☐ Epilepsy/Seizure
   ☐ Other _____

   A. Did the Mental Retardation develop before the individual reached age 18? ☐ Yes ☐ No
   B. Did the Developmental Disability develop before the individual reached age 22? ☐ Yes ☐ No

2. Has the individual received services from an agency that serves persons with MR/DD ☐ Yes ☐ No

   If yes, please provide the name and addresses of this agency. (Include ICF/MR admissions)

   _____
   _____
   _____

3. Is there presenting evidence (cognitive or behavioral) that may indicate the presence of MR or DD? ☐ Yes ☐ No

   A. If yes, does the condition result in substantial functional limitations in three or more of the following areas of major life activity? ☐ Yes ☐ No

   Check appropriate area(s)
   ☐ Self Care ☐ Language
   ☐ Mobility ☐ Self-Direction
   ☐ Independent Living ☐ Learning

4. Does the individual's behavior or recent history indicate s/he is a danger to self (suicidal or self-injurious) or others (combative)? ☐ Yes ☐ No

   If yes, please comment _____

   _____
   _____

MENTAL ILLNESS

1. Does the individual have a diagnosis or history of mental illness? ☐ Yes ☐ No
   If yes, specify diagnosis/es
   ☐ Schizophrenia
   ☐ Schizoaffective
   ☐ Delusional (Paranoia) ☐ Somatoform
   ☐ Psychosis ☐ Other
   ☐ Major Depression ☐ Bi-Polar D/O
   ☐ Panic or other Anxiety Disorder

2. Has the individual been prescribed any psychotropic medications on a regular basis in the absence of a confirmed mental disorder? ☐ Yes ☐ No
   If yes, please list medications.

3. Is there any presenting evidence of disturbance in the orientation, affect, mood or behavior that suggests mental illness?
   ☐ Yes ☐ No

4. Has the individual received treatment within the last two years by any of the following caregivers? ☐ Yes ☐ No
   ☐ Mental Hospital ☐ Hospital Psych. Unit

5. List the name and address of any individual or agency providing diagnosis or treatment for MI. **Important, please list**

6. Does the individual's behavior or recent history indicate that s/he is a danger to self (suicidal or self-injurious) or others (combative)? ☐ Yes ☐ No
   If yes, please comment.

7. Is there a diagnosis of Dementia, OBS, Alzheimer's or any related organic disorders. If yes, complete DMS-780 form.
   ☐ Yes ☐ No

Section III APPLICANT'S STATEMENT

I understand that as a condition of my admission to or continued stay in a Medicaid certified Nursing Facility, a screen (Level I) for indicators of mental illness and/or mental retardation/developmental disability is required by federal law.

I have been informed that the results of the Level I screen may indicate the need for further evaluation (Level II).

I understand that the Level II evaluation will be performed by Bock Associates for the State of Arkansas and that I will be notified in writing of the results of the Level II evaluation.

Signature of Applicant or Responsible Party/Legal Guardian — Date

Signature of Person Completing Level I Screen (Form DMS-787) — Date

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Room Rates

Current Rates:

Care Center Semi-Private Room:	$195.00
Care Center Private Room:	$205.00

*This rate is subject to change due to normal inflationary trends that affect all room rates. Expected room rate increase is 2% per year.

For a Medicaid resident that requests to reside in a Medicaid private room, there will be a room differential rate charge to the responsible party every month. This will be a flat rate of $15.00 per day.

Residents admitted for Medicare Skilled services will not be charged a room rate but services will be billed to the residents Medicare Insurance. Medicare pays for up to 100 days per spell or illness; Medicare pays 100% of the first 20 days of stay and then the last 80 days there is a co-payment per day. Medicaid, supplemental insurance, or private pay will cover this.

Payment is due upon admission and by the tenth of each month thereafter. If payment is not received by the 10th of the month, a late fee of $20.00 will be charged. Payments may be made in the business office, Monday through Saturday. 8:30am to 4:30pm, or mailed to:

Methodist Village Senior Living
7425 Euper Lane
Fort Smith, AR. 72903

Room Rates Include:

1. Private or semi- private rooms available
2. 24-hour nursing care
3. Dietary services as ordered by the physician (excluding IV and tube nutrition)
4. Personal laundry and housekeeping services
5. Recreational activities and entertainment as scheduled
6. Cable television
7. Telephone service

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8. Other facility equipment available includes wheel chairs, walkers, bedside commodes, etc. (not to be removed from the building.)

Room Rates Do Not Include:

1. Private duty nursing
2. Dietary supplements, IV therapies and tube nutrition
3. Prescription medication
4. Fees for any physician's services, speech or physical therapist or other specialists
5. Medical supplies such as Foley catheters, safety or positioning devices, X-ray and laboratory services, etc.
6. Grooming or personal care items other than the house supplies
7. Clothing, or dry- cleaning of clothing
8. Beauty and barber services, see authorization form for in house charges
9. Individual newspaper and other reading material
10. Room décor or Recliner
11. Resident transportation

Transportation Rates:
$50.00 round trip
$25.00 one-way trip

Additional charges for hourly escort use:
$15.00 for the first hour
$10.00 per hour after for subsequent hours
*Revised 3/30/18

These items are listed so the family and resident will know they are not furnished with the usual charge. Most items are available with the assistance of nursing services and/ or social services. If there is a certain item you are concerned about, please do not hesitate to ask.

Meal services are available to family and visitors. Meal tickets are required and may be purchased in the Business Office at a cost of $5.00 per meal. Please notify the Care Center 24 hours in advance to allow the dietary department time to set up a personal table for the resident and his/ her visitor.

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Things to Bring with Application

1. Medicare Card
2. Any Supplement Insurance Card
3. Living Will (If Applicable)
3. Power of Attorney Paperwork (If Applicable)
5. Voided Check from Resident's Bank Account
6. Please Provide Total Monthly Income and Amount of Supplement Insurance Premium. (If Planning to Apply for Medicaid)

****Payment due upon admission****

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Discharge Information Sheet

Patient Name: _____ Date D/C Plan Initiated: _____

Patient plans to discharge to: Home or Facility: _____

Home phone number or cell phone number: _____

Methodist PCP: _____

Primary Care Physician: _____

Ortho Physician: _____

Appt. Dates & Times: _____

Preferred Pharmacy: _____

Home Health Agency: _____

Anticipated Durable Medical Equipment: _____

_____

Medical Alert System Needed: Yes or No Resource Sheet Provided: Yes or No

_____

Caregiving/Housekeeping Resources: _____

Tentative Discharge Date & Time: _____

Other: _____

Patient/Responsible Party Signature:_____

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Admission Prior Level of Function

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Name:	Date:		
Prior Level of Function with ADL's?			
Ambulation prior to hospitalization?	Yes ☐	No ☐	
Ambulation with a device?	Walker ☐	Cane ☐	Other ☐
Ambulation with what type of assist?	1 Person ☐	2 Person ☐	Other ☐
Use of wheelchair?	Yes ☐	No ☐	
Use of electric wheelchair?	Yes ☐	No ☐	
Living Situation:	Home ☐	ALF ☐	Family ☐
	Other ☐		
Caregiver?	Family ☐	Friend ☐	Hired ☐
	Other ☐		
Steps to get into home?	Yes ☐	No ☐	
If yes, how many steps?			
Rails?	Yes ☐	No ☐	
Shower?	Step In ☐	Combo ☐	
Tub?	Step In ☐	Combo ☐	
Shower chair or bench?	Yes ☐	No ☐	
Stairs inside the home?	Yes ☐	No ☐	
How many?			
Cooking own meals?	Yes ☐	No ☐	
Does own laundry?	Yes ☐	No ☐	
Driving?	Yes ☐	No ☐	
Discharge Plan?	Home ☐	ALF ☐	LTC ☐
What must the resident be able to do to discharge to their desired setting?			
Do they have a life alert?	Yes ☐	No ☐	