



**METHODIST VILLAGE**  
SENIOR LIVING

**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)
7. Copy of COVID Vaccination Card

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



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**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: \_\_\_\_\_

7425 Euper Lane

Phone: 479-452-1611

Fax: 479-452-1619

Reviewed and Revised: 4/16/20 KJ; Revised: 4/20/21 DF; Revised: 5/14/21 KJ

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Vaccine: Have you had your COVID-19 Vaccine Yes\_\_\_\_\_ No\_\_\_\_\_

MVSL provided me with educational information regarding the COVID-19 Vaccine.  
Yes\_\_\_\_\_ No\_\_\_\_\_ (Please Initial)

**Physicians:**

Attending Physician: \_\_\_\_\_ Other physicians? \_\_\_\_\_

Optometrist Name: \_\_\_\_\_ Dentist Name: \_\_\_\_\_

Church Membership: \_\_\_\_\_ Pastor: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_

MVSL Room Preference: Private: \_\_\_\_\_ Shared: (Double occupancy) \_\_\_\_\_

**Responsible Party:**

\_\_\_\_\_  
Name Relationship to Applicant

Address: \_\_\_\_\_

Street City State Zip

Phone/Cell: \_\_\_\_\_

**Children/Next of Kin/Emergency Contacts:**

Name: \_\_\_\_\_ Relationship to Applicant: \_\_\_\_\_

Address: \_\_\_\_\_

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Street City State Zip

E-mail Address: \_\_\_\_\_ Phone/Cell: \_\_\_\_\_

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: \_\_\_\_\_

**Preferences:**

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.

Passcode for security for resident information: \_\_\_\_\_

Admitted from: \_\_\_\_\_



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**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 \_\_\_\_\_

**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.**



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**Signature – Responsible Party**

**Date**

\_\_\_\_\_  
**Signature – Responsible Party**

\_\_\_\_\_  
**Date**

**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.

**Grant Consent to Share and Receive Records, for the Purpose of Coordinating Care:**

Allow staff involved in my care to get access to my medical records from my prior caregivers, and to share my current medical record with other providers who can assist in my current or future care.

\_\_\_\_ YES      \_\_\_\_ NO

\_\_\_\_\_  
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 10<sup>th</sup> 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.

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Signature of Resident or Responsible Party



**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**

**Person Completing ID Screen**

Date DMS-787 Completed: \_\_\_\_\_

Name \_\_\_\_\_  
Last First Middle

Name \_\_\_\_\_

Home Address \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

DOB \_\_\_\_\_

Medicaid Number \_\_\_\_\_

Phone ( ) \_\_\_\_\_

Applicant's Current Location:

Home  Hospital  Nursing Home

Comments: \_\_\_\_\_

Other (specify) \_\_\_\_\_

**Guardian/Responsible Party/Next of Kin**

Name \_\_\_\_\_

Address \_\_\_\_\_

Zip \_\_\_\_\_

Phone Number ( ) \_\_\_\_\_

**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

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

If yes, specify diagnosis/es

Mental Retardation  Autism  
 Cerebral Palsy  Epilepsy/Seizure  
 Other \_\_\_\_\_

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

A. Did the Mental Retardation develop before the individual reached age 18?  Yes  No

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

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

If yes, please comment \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

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**MENTAL ILLNESS**

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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.

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Signature of Applicant or  
Responsible Party/Legal Guardian

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Date

---

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

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Date



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**Room Rates**

**Current Rates:**

Care Center Semi-Private Room: \$200.00

Care Center Private Room: \$210.00

\*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 15<sup>th</sup> 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 oxygen, 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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