METHODIST VILLAGE
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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)
7. Copy of COVID Vaccination Card

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

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Reviewed and Revised: 2/12/20, By: KJ; Revised: 4/20/21 DF

METHODIST VILLAGE
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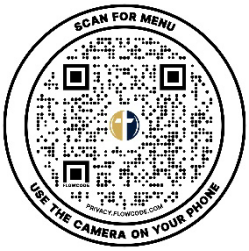
Extremely Important
Please Read

Methodist Village Senior Living (MVSL) is a faith-based, non-profit organization, and we strive to provide the best care to all our residents. We also want you to have realistic expectations, and we want to be upfront and honest and not promise anything we cannot provide.

Before admitting your loved one to MVSL, please remember the following:

- We provide 24/7 care; however, we do not provide one-on-one care.
- Direct Care or Nursing Care is on campus 24/7; however, some departments may not be available after 4pm or on weekends. Such as:
    - Accounting Department
    - Activities Director
    - Administration (however, staff can reach them by phone if there is an emergency)
    - Social Services
    - Rehabilitation (unless therapy is care planned for weekends through our Medical Director)
- If your loved one is falling at home, they can fall after being admitted to MVSL.
- We have many residents who need assistance, and we do our best to aid them as quickly as possible. There may be times when your loved one may need assistance and will need to wait as our staff is caring for another resident. Our staff will help as soon as possible; please do not think they are ignoring you.
- We encourage all our residents to dine in our dining room if possible. This allows for great social interaction. If a resident would rather dine in their room, that is perfectly ok, but please understand there are many residents who cannot eat on their own, and our staff is assisting those residents; therefore, it may take longer than you would like to receive your meal. Our mealtimes are as followed:
    - Breakfast 7:30am – 9:30am
    - Lunch 11:30am – 1:30pm
    - Dinner 4:30pm – 7:00pm
        - We strive to have meals delivered to residents in their rooms as soon as possible; meals can arrive anywhere between these times.
- Please make sure all clothing, personal items, glasses, etc.... are labeled with first and last names. If anything new is brought onto the campus for the resident, please make sure it is labeled. We have over 150 residents on our campus, and we want to make sure all belongings are delivered to the right residents.
    - If something is lost, please notify social services IMMEDIATELY so we can begin looking for lost items.

- If you are the responsible party or POA, you will be the one responsible for letting other family members know of decisions you have made concerning the care of your loved one. **Please keep them informed**. MVSL cannot call all family members listed on admission paperwork. We will first contact the primary responsible party, and if they are unavailable, we will leave a message and wait for a return call. In an emergency, we will contact the primary contact first. If they are unavailable, we will then contact 2nd, then 3rd, and so on until we are able to speak with someone regarding the resident. We can only give medical information to those listed on admission paperwork. We will only take care plan instructions/ physician orders from our Medical Director, Resident, or POA regarding health decisions.
- We would love for you to follow us on social media. We try and post photos of activities, residents (with consent), and important information. Our social media accounts and website are as followed:
    - Facebook- Methodist Village Senior Living
    - Instagram- mvsl_1961
    - Linked In- Methodist Village Senior Living
    - Twitter- mvsl_1961
    - TikTok- mvsl_1961
    - Website- www.methodist village.com
        - Our newsletter is also available on the website.
        - We kindly ask you not to post/take pictures/videos of other residents or staff on social media, as they may not have given consent.
        - We also ask that you do not post on social media any frustrations regarding MVSL, our administration, or our team members. If you have challenges, please let our administrators know so they can be corrected if possible.



- Our Residents and staff love when family and friends join us during our activities, so please come whenever you are available.
- If you have any questions, challenges, or concerns, PLEASE contact the administrator of the facility your loved one is living in. We cannot answer your questions or solve challenges and concerns if we are not aware.

We understand what a difficult choice it is to leave your home and move to a retirement community. So, thank you for choosing Methodist Village Senior Living to be your new home! Welcome to the MVSL Family!

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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

Shirt Size: _____

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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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: _____

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: _____

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
4) Online (Website/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.

_____ _____

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.

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 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

ARKANSAS DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL SERVICES
Level I Preadmission Screen
Major Mental Conditions / Intellectual Disabilities and Related Conditions

SECTION I Applicant Information

Name _____
Last First Middle

Home Address:

Phone Number:
D.O.B.

Medicaid Number
Medicare Number
Social Security Number
Applicant's Current Location:
☐ Home ☐ Hospital ☐ Skilled Nursing Facility
Other (specify)

Guardian/Responsible Party/Next of Kin
Name
Address
Zip
Phone Number

Person Completing Level I Screen
Date DMS-787 Completed: _____

Name:

Employer:

Address:

Phone:

Comments:

Complete All Sections and Answer All Questions | Read and Follow Instructions

SECTION II Level I Screen for Intellectual Disability and Related Conditions

1. Does the individual have a diagnosis or history of intellectual disability (ID) or a related condition? □YES □NO

If yes, specify diagnosis/es:
□Intellectual Disability □Autism
□Cerebral Palsy □Epilepsy/Seizure
□Other:

A. Did the intellectual disability or related condition 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 ID/DD?
□YES □NO

If yes, please provide the name and address of this agency, including ICF/IID admissions:

3. Is there presenting evidence (cognitive or behavioral) that may indicate the presence of ID or DD? □YES □NO

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 □Learning
□Independent Living

4. 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.

Applicant					
	LAST NAME		FIRST NAME		MIDDLE NAME

SECTION III Level I Screen for Major Mental Condition

1. **Diagnosable Major Mental Disorder:** Does the individual have any of the following major mental conditions as diagnosable under the *Diagnostic and Statistical Manual of Mental Disorders, Third Edition, Revised* (DSM-III-R):

   ☐ YES
   ☐ NO

   If YES, check the major mental condition(s) diagnosed or diagnosable for the individual, consistent with DSM-III-R. *Exclude conditions, behaviors, and symptoms caused by a diagnosed (a) major or minor neurocognitive disorder, with or without behavioral disturbances; (b) physical health condition; or (c) non-severe mental health condition:*

   ☐ **Schizophrenia** ☐ **Schizoaffective Disorder** ☐ **Somatoform Disorder**
   ☐ **Bipolar Disorder:** Bipolar Type I or Bipolar Type II ☐ **Major Depression**
   ☐ **Panic or other Severe Anxiety Disorder** ★
   ☐ **Severe Personality Disorder** ★
   ☐ **Other Psychotic Disorder** ★
   ☐ **Other Major Mental Condition with Severe Impairments or Risk of Chronic Disability:** Specify Name of Condition in DMS-III-R: _____

   ★ *This is a category of major, moderate, or mild diagnoses. See DMS-787 Instructions for a list of specific diagnoses considered Major Mental Conditions for PASRR purposes.*

2. **Level of Impairment:** In the past 3-6 months, has the major mental condition(s) identified in Question 1 resulted in at least one of the following functional limitations in the individual's major life activities?

   ☐ YES If YES, check which of these three limitations apply. Check all that apply. Must check at least one for a Yes answer to Question 2. *The limitations are defined in the instructions and 42 CFR § 483.102(b)(1)(ii):*

   ☐ Interpersonal functioning ☐ Concentration, persistence, & pace ☐ Adaptation to change

   ☐ NO

   ☐ N/A Check N/A if the answer to Question 1 is NO.

3. **Recent Treatment History:** Does the individual's treatment history indicate at least one of the following:

   A. Psychiatric treatment more intensive than outpatient care more than once in the past 2 years (e.g., partial hospitalization or inpatient hospitalization).

   B. Within the last 2 years, due to the major mental condition(s) identified in Question 1, experienced an episode of significant disruption to their normal living situation, for which supportive services were required to maintain functioning at home, or in a residential treatment environment, or which resulted in intervention by housing or law enforcement officials.

   ☐ YES If YES, which treatment history above applies (must check at least one for a Yes answer):
   ☐ A. ☐ B. ☐ Both A and B.
   ☐ NO

Applicant					
	LAST NAME		**FIRST NAME**		**MIDDLE NAME**

☐ N/A Check N/A if the answer to Question 1 is NO.

Applicant					
	LAST NAME		**FIRST NAME**		**MIDDLE NAME**

SECTION III Continued

4. **Major Neurocognitive Disorder (MNCD):** Does the individual have a primary diagnosis of a major neurocognitive disorder (formerly called dementia, and includes Alzheimer's and related conditions)?

☐ YES Check YES if the individual has a primary diagnosis of a major neurocognitive disorder, with or without behavioral disturbance.

☐ NO Check NO if (a) MNCD is not diagnosed, (b) MNCD is a secondary diagnosis, or (c) the person is diagnosed with a minor neurocognitive disorder diagnosis.

SECTION IV

APPLICANT'S STATEMENT

I understand that as a condition of my admission to or a continued stay in a Medicaid-certified skilled nursing facility, a screen (Level I) for indicators of major mental condition and/or intellectual disabilities and related conditions 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

METHODIST VILLAGE
SENIOR LIVING

Room Rates

Current Rates:

Care Center Semi-Private Room: $_____

Care Center Private Room: $_____

Respite Care: $_____

*This rate is subject to change due to normal inflationary trends that affect all room rates. The 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.

Respite Care can be provided for up to 13 days.

Payment is due upon admission and by the tenth of each month thereafter. If payment is not received by the 15th 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:
$55.00 round trip
$30.00 one-way trip

Massage Therapy:
$30

Additional charges for hourly sitter use:
$30.00 for the first hour
$15.00 per hour thereafter

Low Air Mattress:
$110

Wheelchair (if not supplied at the time of admission or covered under residents' insurance policy):
Cost of Chair

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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