Greene County MEDICAL CENTER

An Affiliate of UnityPoint Health

Greene County Medical Center
Application for Long Term Care

Name _____ Preferred Name: _____

Current Address _____

City, State, Zip Code _____

Marital Status (circle one) S M W D Social Security #: _____

Spouse (if applicable): _____ Birthdate: _____

Address of spouse (if different): _____

Payment Source: Self/Private Pay _____ Nursing Home Insurance: _____

Medicaid #: _____ Medicaid #: (if applicable) _____

Medicare #: _____

MCO provider (if applicable): _____

Will applicant need to apply for Medicaid within next 6-12 months?

Yes_____ No_____

Is applicant on Elderly Waiver? Yes_____ No _____

Has the applicant ever been convicted of or pled guilty to a felony or sexual offense in a court of law? Yes _____ No _____ If yes, please specify: _____

_____

What type of assistance does applicant receive at home? _____

_____

_____

Physician: _____ Dentist: _____

Pharmacy: _____ Optometrist: _____

Counsellor (if applicable): _____

Funeral Home Preference: _____

Who helps applicant with their affairs? (please list name, address, phone#):

_____

_____

_____

Does applicant have a Durable Power of Attorney for Healthcare?

Yes ____ No____

If so, who? _____

Does applicant have a Power of Attorney and/ or Guardian? Yes ____ No_____

If so, who? _____

We will need all documents pertaining to Advanced Directives, including Durable Power of Attorney for Health Care, Power of Attorney, Guardianship, etc.

Why is applicant needing nursing home care? What is his/her reaction to such care? _____

_____

Immediate family members / other close contact information (list in order to be called by facility)

1) Name_____ Phone: _____

Address: _____

2) Name_____ Phone: _____

Address: _____

3) Name_____ Phone: _____

Address: _____

Because we are required by law to assist the Iowa Commission on Veterans Affairs in identifying residents that are eligible for federal Veterans Administration benefits, we ask that you complete the following:

Is applicant a veteran? Yes_____ No_____

Is applicant's spouse (deceased or living) a veteran? Yes____ No____

Please list veteran's name and date of birth:

Name_____

Birthdate (MM/DD/YYYY): _____

Is ___veteran or ____widow currently receiving monetary benefits?

Yes_____ No_____

Is veteran currently receiving medical VA benefits?

Prescription_____ Treatment_____

Completed by: _____

Date:_____

Reviewed by staff: _____

Date: _____

Thank you for completing this form!

Social History **Name of Applicant**_____

We at Greene County Medical Center Long Term Care feel we can take better care of you if we know something about you. We ask you to please complete this form to help us.

Where were you born? _____

What towns did you grow up in? Where did you go to school?

What is the highest grade you completed? _____

Tell us about your family growing up, your parents and siblings:

Marital Status: Married____ Widowed_____ Divorced_____ Single_____

What is/was your spouse's name? _____

If your spouse has passed away, when? _____

If you have children, what are their names and where do they live?

What occupations have you had? What occupations has your spouse had?

Where have you lived your adult life?

Tell us about your hobbies and interests (ex: reading, crafts, sports, etc). What do you like to do during your spare time?

Do you have a religious/church preference? Yes___ No___

If so, what church? _____

Were you active in your church? Yes___ No__ What did you do?

What organizations/clubs have you been active in?

Do you have a daily activity pattern, such as a routine wake-up time and bed time? How do you usually spend your day?

What foods do you like?

Are there any foods you dislike? If so, what are they?

Do you have any allergies?

Please tell us anything we can do to help you enjoy living in Long Term Care:

Completed by: _____ Date: _____

Reviewed by staff: _____ Date: _____

Thank you for completing this form!

Greene County MEDICAL CENTER
Always Here, Always Caring

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Long-Term Care Financial Document

Thank you for inquiring about the long-term care facility at Greene County Medical Center.

Along with the completed form, copies of the following documents are also required. **If there are any questions regarding this form, please contact the Greene County Medical Center Financial Counselor, Brianna Anderson at 515-386-0278 or Patient Account Representative, Kathy Scheuermann at 515-386-0117 for any questions.**

Documentation check list: *PLEASE DO NOT SEND ORIGINALS*

- ☐ Long-term care insurance policy (if applicable)
- ☐ Last statement for: checking, savings, stocks, bonds, CDs, 401k, IPERS, life insurance
- ☐ Proof of DHS (Medicaid) application (if applicable); Notice of decision (if applicable)

PLEASE NOTE THAT ELECTIVE PROCEDURES MAY NOT BE CONSIDERED FOR ASSISTANCE.

- ☐ I certify all information on this application is true and correct to the best of my knowledge. I understand that provision of any false or misleading information or concealment of a material fact may result in the immediate cancellation of any agreements previously made. I hereby grant permission to Greene County Medical Center to contact the organizations listed on this application to verify information given on this application.

  Applicant Signature:

  _____Date:_____

  Witness:

  _____Date:_____

COMPLETE INFORMATION BELOW: (ALL QUESTIONS MUST BE ANSWERED)

PATIENT NAME:	SOCIAL SECURITY # (REQUIRED):
ADDRESS, CITY, STATE, ZIP:	BIRTH DATE:
HOME PHONE #:	CELL PHONE #:
MARITAL STATUS (CIRCLE ONE): MARRIED SINGLE DIVORCED SEPARATED WIDOWED	

NAME OF THOSE IN THE **HOUSEHOLD**	SEX	SS#	D.O.B	RELATION TO RESIDENT	MONTHLY GROSS WAGES

CHECKING ACCOUNT **YES / NO**	BALANCE:	SAVINGS ACCOUNT **YES / NO**	BALANCE:
STOCKS, BONDS, IRA, CD, **YES / NO**	BALANCE:	4O1K, IPERS **YES / NO**	BALANCE: CASH VALUE:

DO YOU HAVE LIFE INSURANCE FOR YOU OR ANY DEPENDANT OVER 21 WITH A CASH VALUE? **YES / NO** **CASH IN VALUE:**	DO YOU CURRENTLY OWN, OR ARE YOU BUYING REAL ESTATE PROPERTY: **YES / NO**

PERSONAL PROPERTY: PLEASE LIST ALL CARS, TRUCKS, MOTORCYCLES, CAMPERS, OR ANY OTHER RECREATIONAL OR NON-RECREATIONAL VEHICLES. IF MORE SPACE IS REQUIRED, PLEASE ATTACH AN ADDITIONAL SHEET OF PAPER.

ITEM:	MAKE/ MODEL:	YEAR:	OWNER:	AMOUNT OWED:	VALUE:
ITEM:	MAKE/ MODEL:	YEAR:	OWNER:	AMOUNT OWED:	VALUE:

- If unemployed, provide the date employment ended_____. Have you applied for unemployment? **YES / NO**
- If there is no reported income, have you applied for disability? **YES / NO** Are you planning on applying? **YES / NO**
- Have you applied for Medicaid? **YES / NO** Date applied**_____.**

- Did the applicant have insurance at the time of this visit? **YES / NO If yes, please fill out the following information:**

NAME OF INSURANCE:	**EFFECTIVE DATE:**
NAME OF POLICYHOLDER:	**POLICY NUMBER:**

GROSS MONTHLY HOUSEHOLD INCOME: MONTHLY EXPENSES:

WAGES		RENT/ MORTGAGE		CREDIT CARD MINIMUM	
SOCIAL SECURITY		PROPERTY TAXES		LOANS	
UNEMPLOYMENT		PHONE/ INTERNET		MEDICAL BILLS	
PENSION/ COMPENSATION		CELL PHONE		STUDENT LOANS	
INTEREST/DIVIDENDS		GAS/ ELECTRIC		MEDICATION	
ALIMONY		WATER/ SEWER		CAR PAYMENT	
		CABLE/DISH		RECREATIONAL VEHICLE	
		HOME INSURANCE			
		AUTO INSURANCE			
		LIFE INSURANCE			
TOTAL:		HEALTH INSURANCE			

** Please provide proof/documentation of any Public Assistance & Food Stamps. Most common Iowa Public Assistance Programs are: Food Stamps, Energy assistance, cash assistance and vouchers, SSI and Public Housing. Please call Greene County Public Health at 515-386-3228 if you have any questions on these programs.

For new residents: Signed applications and documents must be provided to the Business Office along with $2,000.00 deposit if private payer source (non current Medicaid member) before admission.

For current residents: For current residents who are not Medicaid eligible, signed applications and documents must be returned to the Business Office every year annually.