Maple Woods Assisted Living & Memory Care

33310 State Hwy 6 | PO Box 300 | Deer River, MN 56636 | 218.999.9072 ext.1
Fax 218.246.2490 | mwoods@paulbunyan.net

Application for Residency

GENERAL INFORMATION Date _____

Name _____ Phone (_____)_____

Current Address_____

City, State, Zip_____

Date of Birth_____/_____/_____ Age_____ Social Security Number _____-_____-_____

Gender: ❑ M ❑ F Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced

Race: ❑ Caucasian ❑ African American ❑ Hispanic ❑ Native American ❑ Asian ❑ Other

Disabled: Yes ❑ No ❑ Present Living Arrangements: ❑ House ❑ Apartment ❑ Alone ❑ With Relative

Living Will: Yes ❑ No ❑ Do Not Resuscitate (DNR) Order: Yes ❑ No ❑ (if yes, please attach)

Durable Medical Power of Attorney: Yes ❑ No ❑ (if yes, please attach)

Primary Contact for Application Process

Name_____ Relationship_____

Address_____ City, State, Zip_____

Phone (_____)_____ Work Phone (_____)_____

Email Address_____

Financial Power of Attorney:_____*Medical POA _____

*Guardianship: Name:_____ Phone: _____

*Conservatorship: Name:_____ Phone: _____

PLEASE ATTACH COPIES OF POA, GUARDIANSHIP, AND/OR CONSERVATORSHIP, IF APPLICABLE

Billing and Mailing Information

Name_____ Relationship_____

Address_____ City, State, Zip_____

Phone (_____)_____ Work Phone (_____)_____

Email Address_____

Payer Information

❑ Private Pay ❑ Long Term Care Insurance ❑ Waivered Services ❑ Approved Veterans Benefits

Insurance Information

Medicare #_____ Medicaid #_____

If on Medicaid, Case Worker _____ Phone (_____)_____

Medicaid Waiver Service Coordinator _____ Phone (_____)_____

Veteran's Administration # (if applicable) _____

Supplemental Health Insurance Carrier _____Policy # _____

Application for Residency (continued)

Physician Information

Primary Care Physician Name & Clinic _____

Address_____ City, State, Zip_____

Phone (_____)_____ Fax (_____)_____

Other Medical Providers (psychiatrist, Audiologist, Optometrist, Podiatrist, Cardiologist, Urologist, Dentist)

_____

Name Address Phone Date last seen

_____

Name Address Phone Date last seen

_____

Name Address Phone Date last seen

_____

Name Address Phone Date last seen

Funeral Arrangements

Funeral Home _____

Address_____ City, State, Zip_____

Phone (_____)_____ Prepaid funeral Arrangements? Yes ❑ No ❑

Emergency Contacts

Please list below, in the order you want us to contact them, the names of individuals you want us to contact in case you experience an emergency while living at Maple Woods. Also, indicate whether we can release confidential medical information to that individual.

1st Contact Name: _____ Relationship _____

Address _____ City, State, Zip _____

Phone (_____)_____ Work Phone (_____)_____

Email address _____

Release Confidential Medical Information to this individual: Yes ❑ No ❑

2nd Contact Name: _____ Relationship _____

Address _____ City, State, Zip _____

Phone (_____)_____ Work Phone (_____)_____

Email address _____

Release Confidential Medical Information to this individual: Yes ❑ No ❑

3rd Contact Name: _____ Relationship _____

Address _____ City, State, Zip _____

Phone (_____)_____ Work Phone (_____)_____

Email address _____

Release Confidential Medical Information to this individual: Yes ❑ No ❑

Application for Residency (continued)

Allergies

Medication allergy	Reaction
1._____	_____
2._____	_____
3._____	_____
4._____	_____

Other allergies: (Example latex, tape, etc)	Reaction
1._____	_____
2._____	_____

Medical History

Medical Conditions/diagnosis (please list primary first)

1._____ 4. _____

2._____ 5._____

3._____ 6._____

History of:

Alcohol Abuse: Yes ❑ No ❑ unknown ❑ Drug Abuse: Yes ❑ No ❑ unknown ❑

Smoking: Yes ❑ No ❑ Currently smokes: Yes ❑ No ❑

If yes how much?_____ if quit how long ago?_____

Communication Barriers:

Vision: Yes ❑ No ❑ Correction: _____

Hearing: Yes ❑ No ❑ Correction: _____

Speech: Yes ❑ No ❑ Comments: _____

Activities of Daily Living

Activity	Independent	Needs Assistance	Equipment	Comment
Bathing				
Dressing				
Grooming				
Toileting				
Transferring				
Walking				
Positioning				
Eating				

Application for Residency (continued)

Assistive Device(s)

❑ walker: (Circle) Front wheeled or 4 wheeled with bench seat ❑ wheelchair ❑ toilet riser

❑ mechanical lift ❑brace(s) (List): _____ ❑ other_____

When was the assistive device purchased? _____

Skin

Problem: _____ Treatment:_____

Problem: _____ Treatment:_____

Problem: _____ Treatment:_____

Digestive

Diet_____ Food allergies_____

Appetite_____Weight_____

❑ Indigestion ❑ Heart Burn ❑ Nausea ❑ vomiting ❑ Constipation ❑ Diarrhea

Last BM_____ Nutritional status_____

Dentures: ❑ Top ❑partial ❑full ❑ Bottom ❑ partial ❑ full Other_____

Respiratory

❑ Shortness of Breath ❑ COPD Current use of: ❑ inhalers ❑ nebulizers ❑ oxygen

History of ❑ Bronchitis ❑ pneumonia ❑ sinus infection ❑ Tuberculosis

Urinary

Catheter: ❑ Indwelling ❑ Suprapubic ❑ Condom

Change Schedule/Responsible person_____

Urinary: ❑ Frequency ❑ Urgency ❑ Nocturia ❑ incontinence

History of UTI's or problem with kidney, bladder, or prostate_____

Use of incontinent products? ❑ Yes ❑ No

Where do you purchase the supplies from? _____

Musculoskeletal

❑ Arthritis, describe_____

❑ Joint replacement, Describe_____

❑ Pain: Frequency/Intensity _____

Relieved by_____

Muscular Disorders_____

Application for Residency (continued)

Endocrine

Diabetes ❑ Type I ❑ Type II Date of onset_____ BGM_____

Controlled by: ❑ Diet ❑ Oral Med ❑ Insulin

Describe assistance needed_____

Other Endocrine_____

Cardiovascular

Vital signs:_____

❑ peripheral Edema; Location: _____

❑ High Blood Pressure ❑ low blood pressure ❑History of MI (myocardial infarction)

❑ Coronary artery disease ❑Cerebrovascular accident / Stroke Describe_____

Neurological

❑ Seizure disorder ❑ paralysis_____ ❑ Neuropathies_____

Other_____

Mental Health Needs/Behavior Interventions

❑ Alert Oriented to: ❑ Person ❑ Place ❑ Time ❑Date

❑ Anxious ❑ Forgetful ❑ Depressed ❑ Wanders ❑ Cooperative

❑ Routinely sees a mental health professional ❑Condition/illness Limits

Behavior Socially Acceptable: Yes ❑ No ❑ Describe_____

Responds to Redirections_____

Social Supports

Satisfied with Quality of Life: Yes ❑ No ❑ Family Involvement_____

Friends/Neighbors_____

Community Involvment_____

Church membership/involvement_____

Hobbies Recreation_____

Barriers to pursuing Social Activities_____

Do you have a senior Linkage Number? Yes ❑ No ❑

If Yes, Number: _____

If No, please review the following information, call for your number and enter it above.

Before a Move: Consider Your Options

Are you thinking about moving to a Registered Housing with Services setting*?

Before you sign a lease or housing contract you need to call the Senior LinkAge Line® for Long Term Care Options Counseling. It can help you find services that meet your needs.

To receive the service, call the Senior LinkAge Line® at 1-800-333-2433. The Senior LinkAge Line® helps people and their families find local resources and make decisions about long-term services and supports.

You do not need to call in the following situations:

1. You are entering into a *lease-only* arrangement in a subsidized housing setting.
2. You had a Long Term Care Consultation and got verification of the consultation (verification code).
3. You are currently receiving or are being evaluated for hospice services from a licensed hospice provider.
4. You developed a financial long-term care plan within 12 months before you sign and lease or contract. The plan needs to include the following:
   - The plan lists an alternate decision maker if you are unable to make your own financial or health care decisions.
   - The plan covers the financing of the rent and service costs for 60 months after the date you move, and does not include public program payments such as Medical Assistance or Group Residential Housing.
5. You moved into the housing setting on an emergency basis.

*Housing with services providers are registered by the Minnesota Department of Health.

When you call, you will talk with an expert. Together, you will:

- Look at your current situation.
- Find services that may be helpful to you.
- Learn about financing options. These resources might help you pay for services you may need.

Take the following important steps:

1. Call the Senior LinkAge Line® at 1-800-333-2433. Or, use the Minnesota Relay Service at 711 or 1-800-627-3529 (TDD). Or call 1-877-627-3848 (speech-to-relay service).
2. The Specialist will ask you some basic questions and discuss your options.
3. At the end of the call you will receive a verification number.
4. Write down the number and put it in a safe place.
5. You will receive a copy of the number by mail.

If you decide to move, give your verification number to the housing provider. Do this before you sign a lease or housing contract.

If you decide not to move, keep the number in a safe place should you later need it.

The Senior LinkAge Line® is a statewide service of the Minnesota Board on Aging and is provided locally through six Area Agencies on Aging. The Senior LinkAge Line® is available by phone at 1-800-333-2433, Monday through Friday, 8:00 a.m. to 4:30 p.m.

MBA-2010-ENG

What this means for you:

- Make just one call for help with making decisions about services or finding help.
- Have better information to make choices.
- Get support to consider all of your options.
- Make the right choice at the right time for you.

MINNESOTA
SENIOR LINKAGE LINE

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RELEASE OF INFORMATION

Name _____ Admit Date: _____

Date of Birth_____/_____/_____ Social Security Number _____-_____-_____

Personal, financial, and medical information will be kept private without permission of a client or client's responsible person. Sharing of this information with other health care or third party payers such as health insurance providers, medical assistance, Medicare, or other health programs may be necessary to the provision and payment of your care.
Review the following information and initial any or all persons/organizations to whom the above information may be disclosed.

Applicable personal, financial, and medical information may be released to the following persons/organizations only as it relates to the home care services being provided by:
Licensee Name: **Maple Woods Assisted Living & Memory Care**
Address: **33310 State Hwy 6, Deer River MN 56636**

- ❑ Other health care providers as necessary for the provision of health care services
- ❑ Health insurance provider/HMO
- ❑ Medical Assistance
- ❑ Medicare
- ❑ Other: (identify) _____
- ❑ Other: (identify) _____
- ❑ I do not want information released to: (identify)_____

_____ _____
Client/Responsible Party Signature Date