App #

FOSS HOME APPLICATION FOR RESIDENCY

GENERAL INFORMATION

Application Date_____ Are you interested in residency: Now? [ ] In the future? [ ]

Is there a need for a secure alzheimer's unit, (i.e., would resident be at risk for wandering or exit seeking)? Yes [ ] No [ ]

Are you interested in a private room? Yes [ ] No [ ]

Name_____[ ] M [ ] F _____
Last *First* *M.I.* *Phone*

Residence_____
Street/PO Box

_____
City, State, Zip

Marital Status: [ ] Married [ ] Single [ ] Separated [ ] Divorced [ ] Widowed
Spouse Name, if applicable_____

Social Security #_____Medicare #_____Medicaid #_____

Previous Occupation_____ Religious Preference_____

Date of Birth_____ Place of Birth_____

US Citizen? [ ] Yes [ ] No

Preferred Funeral Home_____ Phone_____

Please indicate your preference regarding mail distribution:
[ ] All mail to resident
[ ] Personal mail only to resident; rest (bills) to responsible party.
[ ] All mail to responsible party
[ ] Other:_____

MEDICAL/PROVIDER INFORMATION

Personal Physician_____
Will this physician follow you to Foss? [ ]Yes [ ]No

Is applicant coming to Foss Home from the hospital? [ ] Yes [ ] No
If yes, name of Hospital_____

Reason for Hospitalization_____

Hospital Discharge Planner_____ Phone_____

Diagnosis/Health Issues_____

Current medications and treatments_____

_____

Have you had previous nursing home stay(s)? [ ] Yes [ ] No

If yes, when and where?_____

Has **PASARR*** been done? [ ] Yes [ ] No
What were results? [ ] Positive [ ] Negative
If positive, has D.S.H.S. been notified? [ ] Yes [ ] No

What special equipment is needed? [ ]Intravenous fluids [ ]Tube feeding [ ]Oxygen treatment
[ ] Other_____

Do you smoke? [ ] Yes [ ] No Do you drink alcoholic beverages? [ ] Yes [ ] No

Do you have a Living Will/Directive to Physician? [ ] Yes [ ] No

Do you have a Durable Power of Attorney for Health Care? [ ] Yes [ ] No

FINANCIAL INFORMATION

Do you have a Durable Power of Attorney for Finances? [ ] Yes [ ] No

Person responsible for receipt and payment of billing statements:

_____ _____
Name *Relationship*

_____ _____
Address *Home Phone*

_____ _____
City, State, Zip *Business Phone*

How will Foss account be paid upon hospital discharge?
[ ] Private Pay [ ] Medicaid [ ] Medicare [ ] Private Insurance

If private insurance, please describe below:

1._____
Company *Policy Number*

2._____
Company *Policy Number*

If Foss Account will be paid by Medicare or Insurance, how will it be paid after the discontinuation of Medicare or Insurance?_____

EMERGENCY CONTACTS

First contact:

_____ *Name*	_____ *Relationship*
_____ *Address*	_____ *Home Phone*
_____ *City, State, Zip*	_____ *Business Phone*

Second contact:

_____ *Name*	_____ *Relationship*
_____ *Address*	_____ *Home Phone*
_____ *City, State, Zip*	_____ *Business Phone*

Applicant Signature/Legal Representative_____

Legal Representative's Relationship to Applicant_____

***PASSAR:** The federal Omnibus Budget Reconciliation Act of 1987 (Public Lay 100-203), subsection 1919(e)(7) and as amended by OBRA 1990, requires that all individuals applying for or residing in a Medicaid-certified facility be screened to determine whether an individual:

1. Has a serious mental illness, mental retardation or related conditions; and, if so,
2. Requires the level of services provided by a nursing facility; and
3. Requires specialized services.

The purpose of the identification screen is to determine which nursing facility applicants are likely to have a serious mental illness or developmental disability and are subject to the Preadmission Screening and Annual Resident Review (PASSAR).