

APPLICATION FOR ADMISSION
PINE HAVEN CHRISTIAN COMMUNITIES
531 Giddings Avenue
Sheboygan Falls, Wisconsin 53085
Telephone (920) 467-2401

PHCH-CBRF
Fax#: (920) 467-1568

PHCH-NH
Fax#: (920) 467-2573

PRAIRIE CROSSING
Fax#: (920) 467-2489

OOSTBURG

Name of Applicant _____
Last First Middle

Street Address _____
City State Zip Code

Telephone _____ Date of Birth _____ Place of Birth _____

Social Security # _____ Medicare # _____

Other Medical Insurance-Name _____ # _____

Church Membership _____ Pastor _____ Telephone # _____

Military Service (Applicant & Spouse) _____

Personal Physician _____ Telephone # _____

Personal Dentist _____ Telephone # _____

Hospital Preference _____ Funeral Director _____

CHILDREN: (or Relatives or Friends) (List in order of responsibility)

Name _____ Relationship _____

Street Address _____ Telephone (Home) _____

City State Zip Code (Work) _____
(Cell) _____

Name _____ Relationship _____

Street Address _____ Telephone (Home) _____

City State Zip Code (Work) _____
(Cell) _____

Name _____ Relationship _____

Street Address _____ Telephone (Home) _____

City State Zip Code (Work) _____
(Cell) _____

AGREEMENT:

I (we) hereby make application for residency at Pine Haven Christian Communities and promise to meet the social and financial requirements for residency.

I (we) understand that this application is not binding to either party until actual admission is made. I further understand that the material given herein will be used in confidence and with professional discretion.

I understand that to appropriately meet my physical needs it may be necessary for the Pine Haven Staff (including various health care professionals and para-professionals retained by the Administrator) to review my medical records and I specifically authorize such disclosure.

I designate that the persons listed above be notified of any significant accident, injury, or adverse change, or other non-medical changes, including financial, discharge, or transfer.

Signed _____ Date _____

RESIDENTIAL CENTER – APPLICATION STATUS

Active - desires admission or room hold to Pine Haven at first opportunity

Inactive – desires placement on waiting list but not seeking admission until later time

Admission is determined by:

- initial date of application on the active list
- date application is requested to be placed on the active list from the inactive list
- last date of refusal to Pine Haven Residential Center

(Applicants may refuse admission one time on the active list before being automatically placed on the inactive list. Applicant/family must notify Administrator or Social Worker to re-activate their application)

Room Assignments -

Room assignments are determined by room availability, applicant’s preference and recommendations made by the CBRF staff upon completion of the nursing assessment in regard to any mobility restrictions.

I hereby declare that my application to Pine Haven be:

_____ Active

_____ Inactive

******* A SEPARATE APPLICATION MUST BE COMPLETED FOR NURSING HOME CONSIDERATION**

Signed _____

Date _____

SOCIAL HISTORY

Resident's Name _____ Physician _____ Date _____

Name preferred? _____ Admission Date _____

We have found through experience that the more we know about our residents prior to admission to our facility, the more we can help the resident after admission. Often details of a person's past life, about which we never thought to ask, turn out to be important factors for their happiness here. Your replies are completely confidential and will be used only for professional purposes. Sending the completed form in advance will save you time upon admission. If you are uncertain about any questions, please call and you can discuss them with us.

I. CURRENT SITUATION

A. Care of self (check). It will be helpful to know about the resident's usual day.

	Alone	Needs Help	Unable
1. Dressing			
2. Washing hands and face			
3. Bathing and skin care			
4. Get in and out of bed			
5. Get in and our of chair			
6. Care of hair			
7. Care of fingernails			
8. Care of toenails			
9. Shave			
10. Brush own teeth and/or dentures			
11. Use toilet			

12. Bowel control
 Frequency _____ Normal Occasional loss of control Unable to control
 Time of day _____ Enemas Uses suppositories
 Any "aids" used _____

13. Bladder control
 Frequency _____ Normal Occasional loss of control Unable to control
 Time _____ Catheter

B. Walking (check all that apply)

- | | | | |
|--|---|-------------------------------------|---|
| <input type="checkbox"/> Normal | <input type="checkbox"/> Climb stairs | <input type="checkbox"/> Brace | <input type="checkbox"/> Wheel chair |
| <input type="checkbox"/> Slow but steady | <input type="checkbox"/> Up in chair only | <input type="checkbox"/> Cane(s) | <input type="checkbox"/> Electronic mobility device |
| <input type="checkbox"/> Unsteady | <input type="checkbox"/> Bedridden | <input type="checkbox"/> Crutch(es) | |
| <input type="checkbox"/> No walking | <input type="checkbox"/> Artificial limb | <input type="checkbox"/> Walker | |

Describe falls or injuries resident has had _____

II. PAST LIFE

A. Early family life

1. Where born and raised? _____
(If foreign born) Age came to U.S. _____ Citizen now? _____ Language spoken _____
2. Father's name _____ Birth place _____
3. Mother's maiden name _____ Birth place _____
4. Names of brothers and sisters (alive) and present contacts and relationships with resident. _____

5. Name of brothers and sisters (deceased) _____

B. Education

Highest level completed? _____ Vocational training? _____

C. Occupation

Main jobs _____

D. Travels

Where and When? _____

E. Retirement

1. Planning in advance _____
2. Date of retirement? _____ Voluntary or involuntary? _____
3. Reaction to retirement? _____
4. Work subsequent to retirement? _____

F. Marriage (if wife, give maiden name)

1. Spouse's name _____
2. Date of marriage _____
3. Widowed Reaction to death of spouse _____
4. Divorced Reaction to divorce _____
5. Describe the important characteristics of the marriage as you know it _____

6. Children _____
Name _____ Spouse's name _____
Grandchildren _____
Present contacts and relationships with resident _____

Name _____ Spouse's name _____
Grandchildren _____
Present contacts and relationships with resident _____

Name _____ Spouse's name _____
Grandchildren _____
Present contacts and relationships with resident _____

Name _____ Spouse's name _____
Grandchildren _____
Present contacts and relationships with resident _____

Is there any other information you think we should know to assist us in caring for the resident? (Write on separate sheet and attach).

Completed by/relationship: _____ Date ___/___/___ Reviewed by: _____ Date ___/___/___

SO YOU'RE THINKING
ABOUT A GROUP HOME

Have you thought about how you will pay for your care?
What will happen if our money runs out?

If you are thinking about care for yourself or a love one in a community-based residential facility (group home), you have probably considered the various benefits these homes offer and may be anxious to go on with the process of admission...but before you sign on the dotted line,
Here are a few things to consider

Myth #1: I can receive state or federal funds to cover my care in a group home after I give most of my money to my kids.

Fact: Most long term care programs follow Medicaid (Title 19/Medical Assistance) eligibility guidelines which consider any money given to others, other than for personal care services, to be a divestment of assets which makes them ineligible for funding for up to 30 months.

Myth #2: If I run out of money for my care, I can apply for Medicaid (T-19) to cover my care in the group home.

Fact: Medicaid does not cover group home (CBRF) care. Be sure you know if the facility you are interested in is licensed as a CBRF or a nursing home.

Myth #3: Well, they can't just put me out on the streets.

Fact: A group home has the legal right to ask you to leave if you cannot pay their rate.

BASIC FACT:

You need to find out the facts now before you leave your present home! Contact your County Department of Human Services. They can assess your needs, at no cost to you, and advise you of alternatives as you make decisions about how to best meet your care needs. You might be eligible for assistance that would enable you to stay at home or assist you to live with relatives. Call 459-3095. Ask for Adult Services Intake.