Application for Admission

Applicant Information

Full Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

Social Security Number: _____ Date of Application: _____

DLTC Healthcare & Bella Point Release of Information Completed and Included? *(attached, page 4)* ☐ YES ☐ NO

Facility Applied To: *(please check all that are applicable)*

☐ Any/All	☐ **Bayview Manor** *45 W Main St, Searsport*	☐ **Capitol City Manor** *313 State St, Augusta*
☐ **Crawford Commons** *132 Middle Rd, Union*	☐ **East Point** *96 Stackpole Dr, Machias*	☐ **Halldale Manor** *647 Maine Ave, Farmingdale*
☐ **Hilltop Manor** *462 Essex St, Dover-Foxcroft*	☐ **The Lamp Memory Care Center** *64 Lisbon St, Lisbon*	☐ **The Lodges Care Center** *51 Main St, Springvale*
☐ **Pleasant Meadows Estates** *137 Park St, Dover-Foxcroft*	☐ **Rising Hill** *95 Access Hwy, Limestone*	☐ **Tissues Country Estates** *212 Fox Hill Rd, Athens*
☐ **Wellmore Point** *40 Palmer St, Calais*	☐ **Bella Point Bridgton** *186 Portland Rd, Bridgton*	☐ **Bella Point Camden** *51 Mechanic St, Camden*
☐ **Bella Point Freeport** *3 East St, Freeport*	☐ **Bella Point Fryeburg** *70 Fairview Dr, Fryeburg*	☐ **Bella Point Sidney** *888 Pond Rd, Sidney*
☐ **Prince Point** *191 Foreside Rd, Falmouth*	☐ Unsure	

Financial Information

Payor Source: ☐ **Long Term MaineCare** ☐ **Private/Self Pay**

(If LTC MaineCare, please answer questions in section #1 below. If Private/Self Pay, please skip to #2.)

1. Long Term MaineCare Only
   a. Monthly Income: _____ Source(s): _____
   b. MaineCare ID #: _____
   c. Long Term MaineCare Application Completed? ☐ YES- Date Submitted to DHHS: _____ ☐ NO
   d. Maximus Assessment Completed and Included? ☐ YES- Date Completed: _____ ☐ NO
   e. DHHS Release of Information Completed and Included? *(attached, pages 5-6)* ☐ YES ☐ NO
   f. DHHS Caseworker Information: Name: _____ Phone/Email: _____

2. Private/Self Pay Only
   a. Monthly Income: _____ Source(s): _____
   b. Financial Institution Name(s): _____
   c. Income Verification Form Completed and Included? *(attached, page 7)* ☐ YES ☐ NO
   d. Three (3) Months' Bank Statements Included? ☐ YES ☐ NO

Applicant's Contacts/Responsible Party Information

Emergency Contact:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #: _____

Legal Guardian? ☐ YES ☐ NO Medical POA? ☐ YES ☐ NO Financial POA? ☐ YES ☐ NO

Contact #1:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #: _____

Legal Guardian? ☐ YES ☐ NO Medical POA? ☐ YES ☐ NO Financial POA? ☐ YES ☐ NO

Contact #2:

Name: _____ Relationship to Applicant: _____

Address: _____ Phone #: _____

Legal Guardian? ☐ YES ☐ NO Medical POA? ☐ YES ☐ NO Financial POA? ☐ YES ☐ NO

**Please attach copies of documentation showing POA/Legal Guardianship if applicable. Additional contacts can be added during the admission process.*

Applicant's Medical Information

Most Recent History & Physical Attached to this Application for Review *(required)*: ☐ YES ☐ NO

Primary Medical Diagnosis: _____

Allergies: _____

Special Diet Information: _____

Living Will: ☐ YES *(please attach)* ☐ NO Do Not Resuscitate Order: ☐ YES *(please attach)* ☐ NO

Smoking Status *(please note all our facilities are nonsmoking)*: ☐ Nonsmoker ☐ Former Smoker ☐ Current Smoker

Please List All Current Medications: ☐ Separate Medication List Attached

Provider Information

a. Primary Care Provider Name: _____

   a. Clinic Name: _____

   b. Address: _____

   c. Phone: _____ Fax: _____

b. Dentist Name: _____ Clinic Name: _____

Physical Status Information *(please note none of these are disqualifying, this information is helpful for us to know.)*

a. Do you wear glasses: ☐ YES ☐ NO

b. Are you able to walk without assistance: ☐ YES ☐ NO

c. Are you able to walk with a cane/walker: ☐ YES ☐ NO

d. Are you able to bathe without assistance: ☐ YES ☐ NO

e. Are you able to dress without assistance: ☐ YES ☐ NO

f. Are you able to eat without assistance: ☐ YES ☐ NO

g. Are you able to handle all of your toileting needs without assistance: ☐ YES ☐ NO

h. Are you on any injectable medications: ☐ YES ☐ NO

i. Do you have any of the following- catheter, ostomy, skin wounds: ☐ YES ☐ NO

j. Other information regarding physical status and/or care needs:

_____

_____

_____

Name of Individual Completing/Assisting with Application: _____

Relation to Applicant/Referring Agency: _____

DLTC Healthcare & Bella Point does not discriminate against otherwise qualified applicants for admission on the basis of race, color, creed, religion, ancestry, age, sex, marital status, national origin, disability or handicap, or veteran status.