

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)*

<input type="checkbox"/> Any/All	<input type="checkbox"/> Bayview Manor <i>45 W Main St, Searsport</i>	<input type="checkbox"/> Crawford Commons <i>132 Middle Rd, Union</i>
<input type="checkbox"/> East Point <i>96 Stackpole Dr, Machias</i>	<input type="checkbox"/> Halldale Manor <i>647 Maine Ave, Farmingdale</i>	<input type="checkbox"/> Hilltop Manor <i>462 Essex St, Dover-Foxcroft</i>
<input type="checkbox"/> The Lamp Memory Care Center <i>64 Lisbon St, Lisbon</i>	<input type="checkbox"/> The Lodges Care Center <i>51 Main St, Springvale</i>	<input type="checkbox"/> Pleasant Meadows Estates <i>137 Park St, Dover-Foxcroft</i>
<input type="checkbox"/> Prince Point <i>191 Foreside Rd, Falmouth</i>	<input type="checkbox"/> Rising Hill <i>95 Access Hwy, Limestone</i>	<input type="checkbox"/> Seal Cove <i>19 General Moore Way, Ellsworth</i>
<input type="checkbox"/> Tissues Country Estates <i>212 Fox Hill Rd, Athens</i>	<input type="checkbox"/> Wellmore Point <i>40 Palmer St, Calais</i>	<input type="checkbox"/> Bella Point Bridgton <i>186 Portland Rd, Bridgton</i>
<input type="checkbox"/> Bella Point Camden <i>51 Mechanic St, Camden</i>	<input type="checkbox"/> Bella Point Freeport <i>3 East St, Freeport</i>	<input type="checkbox"/> Bella Point Fryeburg <i>70 Fairview Dr, Fryeburg</i>

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.



AUTHORIZATION FOR RELEASE OF INFORMATION

Date: _____ Facility: _____

Facility Address: _____

Resident Name: _____ SS#: _____

I hereby authorize the above facility to provide information in accordance with the facility policy relating to my history, treatment, and services provided to me by the facility. This information may be released to the following service providers

Hospital _____	Mental Health Center _____
DMR _____	Dentist _____
Podiatrist _____	Medical Doctor _____
PT _____	OT _____
RN Consultant _____	Optometrist _____
Consulting MD _____	Consulting MD _____
Psychiatrist _____	Case Worker _____
Family _____	Family _____
Home Health _____	Ambulance Service _____
Pharmacy _____	Other _____
Other _____	Other _____

PointClick Care (for computerized data base) _____

Corporate Office (for computerized data base) _____

Note: This authorization expires not later than 30 months from the date of signing and may be revoked either orally or in writing by the resident or guardian at any time.

Expiration Date: _____

_____ Resident/Guardian	_____ Witness (Facility Representative)	_____ Date
Review/Update _____	Review/Update _____	
Review/Update _____	Review/Update _____	

Revocation of Authorization (only sign below if revoking this release of information):

_____ Resident/Guardian	_____ Witness	_____ Date
----------------------------	------------------	---------------



Authorization to Release Information

We are committed to the privacy of your information.
Please read this form carefully.

Which office(s) should help you? Please check.

<input checked="" type="checkbox"/> Office of MaineCare Services	<input type="checkbox"/> Office of Behavioral Health
<input checked="" type="checkbox"/> Office for Family Independence and Medical Review Team	<input type="checkbox"/> Office of Child and Family Services
<input type="checkbox"/> Maine Center for Disease Control and Prevention	<input type="checkbox"/> Office of Aging and Disability Services
<input type="checkbox"/> Dorothea Dix Psychiatric Center	<input type="checkbox"/> Office of Administrative Hearings
<input type="checkbox"/> Riverview Psychiatric Center	<input type="checkbox"/> Other:
<input type="checkbox"/> Division of Licensing and Certification	<input type="checkbox"/> Other:

Whose information will be disclosed? Please print clearly.

Individual's Name	Date of Birth		
Home Address	Town/City	State	Zip Code
Telephone	Email address of individual/personal representative (optional)		

Please check: Release/Send my information to: Obtain/Get my information from:

Name of Individual	Organization		
Address	Town/City	State	Zip Code
Telephone	Email address (optional)		

What is the purpose of the disclosure?

<input type="checkbox"/> Personal request	<input checked="" type="checkbox"/> To coordinate or manage my care
<input type="checkbox"/> For a legal matter, including testimony	<input checked="" type="checkbox"/> To see whether I qualify for insurance coverage, services, or benefits
<input type="checkbox"/> Other:	

To share the information with others by EMAIL, please initial and complete the following.

I understand that email and the internet have risks that the office sharing my information cannot control. It is possible that my emailed information could be read by a third party. I ACCEPT THOSE RISKS and still ask to send my information by email. INITIAL HERE _____
Please print the email address where you want your information sent:

What information should be released or obtained? Please check all that apply.

<p><u>General permission:</u></p> <p><input type="checkbox"/> All health information from the office(s) checked above</p> <p><input type="checkbox"/> Claims or encounter data (information about visits to health care providers)</p> <p><input type="checkbox"/> Billing, payment, income, banking, tax, asset, or data needed to see if you qualify for DHHS program benefits</p> <p><input type="checkbox"/> Limit to the following date(s) or type(s) of information: (for example “Lab test dated June 2, 2019” or “Claims from 2018-2020”)</p> <p><input type="checkbox"/> Other: _____</p>	<p><u>Special permission: Drug/Alcohol Treatment or Referral for Services</u></p> <p><input type="checkbox"/> Include all drug/alcohol information in the release</p> <p><input type="checkbox"/> Include only the specific drug/alcohol records checked:</p> <p><input type="checkbox"/> Diagnosis and treatment</p> <p><input type="checkbox"/> Clinical notes and discharge summaries</p> <p><input type="checkbox"/> Drug/Alcohol history or summary</p> <p><input type="checkbox"/> Payment or claims information</p> <p><input type="checkbox"/> Living situation and social supports</p> <p><input type="checkbox"/> Medication, dosages or supplies</p> <p><input type="checkbox"/> Lab results</p> <p><input type="checkbox"/> Other: _____</p>
<p><u>Special permission: Mental/Behavioral Health Services</u></p> <p><input type="checkbox"/> Include this information in the release</p> <p><input type="checkbox"/> I want to review my mental health/behavioral health record before release. I understand that the review will be supervised.</p> <p>Please note: Maine law allows us to share this information with other health care providers and health plans to coordinate and manage your care (to help take care of you) so long as we make a reasonable effort to notify you of the release.</p>	<p><u>Special permission: HIV/AIDS Status/Test Results</u></p> <p><input type="checkbox"/> Include this information in the release</p> <p>Please note: Maine law requires us to tell you of possible effects of releasing HIV/AIDS information. For example, you may receive more complete care if you release this information, but you could experience discrimination if it is misused. Your HIV/AIDS-related information, and all of your data, will be protected as the law requires.</p>

I understand and agree that:

- I am signing this form voluntarily. I have the right to a signed copy of this form if I request one.
- My treatment, payment for services, or benefits will not depend on whether I sign this form unless I am requesting or disclosing information to apply for benefits.
- “Information” may be in written, spoken and/or electronic format, and includes information about me from other healthcare providers (such as doctors, hospitals, and counselors) that is included in my files. My signature allows the people/offices named on the reverse to discuss my information for the purposes noted on this form.
- My information will be kept confidential as required by law. If I choose to share my information with others who are not required by law to keep it private, it may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program (substance use disorder) records are included in this release, a notice will be included with the records saying that such information may not be re-released or shared without my written permission.
- I may revoke (take back) my permission to release my information by filling out the Revocation Form found at <http://www.maine.gov/dhhs/privacy/index.shtml> and sending it to the office that shared my information. The Revocation Form is effective only after it is received and does not apply to information that was already shared.
- If I take back my permission or refuse to release some or all of my information, my choice could lead to an improper diagnosis or treatment, or denial of insurance.
- This form expires **one year** from the date below unless I write an earlier date here: _____
- This form permits additional releases until it expires.

Date: _____ **Signature:** _____

Personal Representative’s authority to sign: _____



Income Verification Form (Private/Self Pay Only)

Name of Applicant: _____ Date: _____

POA (if applicable) _____ DOB: _____

Financial Information

Bank Name: _____

Account Type: Checking / Savings
(Please Circle One) Current Account Balance: \$ _____

Bank Name: _____

Account Type: Checking / Savings
(Please Circle One) Current Account Balance: \$ _____

Bank Name: _____

Account Type: Checking / Savings
(Please Circle One) Current Account Balance: \$ _____

Please list any assets: (vehicles, houses, stocks, bonds, life insurance policies)

Account Type	Estimated Value	Debts Against Asset
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

By signing this document you are authorizing DLTC Healthcare to contact all institutions listed on this form to verify balances and assets listed.

Signature _____

Date _____