The Martin-Linsin Residence

at Hospice of Orleans

Application Packet

Revised Date 06-21-16

MARTIN LINSIN RESIDENCE AT HOSPICE OF ORLEANS
Residence Application

Dear Hospice Family:

To be considered for the Martin-Linsin Residence, please provide the following:

- 3 months of bank, investment and any other supporting financial records
- A complete Residence application (attached)

This information should be provided to your Hospice Social Worker or the Admissions Nurse, who will give it to the financial department at Hospice of Orleans. All information will be kept confidential. Once a patient is cleared financially they can be added to the list of interested patients and will be considered when a Residence bed is available.

Cost of Unit; A brief review:

- If you have Medicaid, both medical care and room and board will be covered – you may have a responsibility for some payment based on your Spend Down determined by Medicaid.
- If you have Medicare or Private Insurance only medical care will be covered, however, you will be responsible for the room and board charges.
- The Hospice Social Worker or Admissions Nurse will assist you in determining what portion of the fee will be your responsibility
- An advance payment will be due before transfer of the patient to the Residence.

Revised Date 06-21-16

SECTION A - Admissions Agreement

Patient ID: _____

I,_____, request admission to the Martin-Linsin Hospice Residence ("Residence") and acknowledge, consent and agree to the following:

I, _____as Health Care Proxy and/or the member of the immediate family and/or the responsible party for the above named applicant, request his/her admission to the Residence and agree to the following:

COVENANTS

1. I understand that the care provided at the Residence is palliative and not curative; that the care provided emphasizes symptom relief and emotional/spiritual support.

2. I understand my prognosis and that I am required to complete, sign and provide a copy of a DNR/MOLST form to Hospice of Orleans, inc.

3. I understand that should my care needs change or my acceptance of the Hospice philosophy changes, transfer and discharge to an appropriate level of care/facility will be initiated by Hospice staff. In the event of such action, Hospice will inform patient and responsible party of options and discharge rights.

4. I approve for notations to be made in my medical record regarding my care at the Residence.

5. I agree to accept a Hospice physician as my primary care provider during my stay at the Residence or my primary physician agrees to provide care while I am in the Residence.

6. I understand that it is recommended, prior to admission to the Residence, to have and submit a copy of a health care proxy, advanced directives for health care decisions and a durable power of attorney for financial decisions.

7. I understand that Hospice of Orleans will attempt to secure payment for services from third party payors. I shall provide all necessary materials required of third party payors for Hospice of Orleans to collect payment on my behalf.

8. I understand that I or my legal responsible party is ultimately responsible for Residence charges in the event of third party payor decline of payment or partial payment. I further acknowledge that failure to make payment or provide necessary materials/documentation to remit a request for payment to a third party payor may result in discharge from the Residence and legal action.

9. I understand that medical services and cost of medications not related to my terminal diagnosis will be charged to my primary third party payer source or will be billed separately to me or my legal responsible party. The patient or legal responsible party must provide Hospice of Orleans with all necessary information from a valid charge card. The charge card will only be used in cases when there are outstanding patient related costs.

Revised Date 06-21-16

10. I understand that I may drink alcohol as directed by my physician and that disruptive behavior may result in discharge from the Residence.

11. I understand that admittance to the Residence will be based on need and availability. I agree to being assigned or transferred to another room as may be necessary.

12. I understand that smoking, possessing illegal drugs or weapons is not permitted in the Residence or on facility grounds.

13. I understand that visitors may be limited at any time at my request. Visitors causing disruption will be asked to leave.

14. I understand that I may voice my concerns regarding the care provided at the Residence and that I will not be harassed or discriminated against for making a complaint.

15. I understand that my home address will become the address of The Martin-Linsin Residence, 14084 Route 31 West, Albion, NY 14411 during my stay.

16. I hereby authorize services to be provided to me at the Residence and accept full responsibility for payment of such services.

17. I understand that the Residence shall not be responsible for any monies, valuables, or personal effects brought into the Residence by me or my guests. I acknowledge that a locked drawer is available in my suite for securing my personal effects.

18. I understand that I may leave the Residence with physician approval and that I shall notify the Residence of my departure and duration. I agree to hold harmless Hospice of Orleans for any liability during my period of departure.

19. I understand that all admissions and discharges enter and exit thru the front door as a tribute to the dignity of each patient. To that end, should a patient of the Residence pass away during my stay, the staff will close the suite doors and proceed to remove the deceased thru the hallway exiting the front door. Once the deceased is removed, the Residence staff will re-open the patient suite doors.

20. I understand that the Residence may have cause to increase the daily rates. Hospice of Orleans shall provide thirty (30) days advance notice of effective date.

21. I understand that the amenities and accommodations of the Residence are available for myself and my guests and that use of these amenities are done so at the users own risk.

22. I acknowledge that the provision of services shall include but not be limited to:
    a. The services of a registered professional nurse who is available to provide direct patient care on a 24-hour-a-day basis.
    b. Accommodations to enable families to store and prepare food brought in by the family.

Revised Date 06-21-16

c. Accommodations to enable families to remain with the patient 24-hours-a-day.
d. 24-hour visitation access regardless of age of visitor.
    1. Visitors under the age of 16 must be supervised at all times.
e. Provision of adequate and wholesome food and supplemental nourishments under the direction of a registered dietician.
f. Offer each patient at least 3 meals a day, or their equivalent, each at regular times with no more than 14 hours between a substantial evening meal and breakfast.
g. Flexibility in meal times and in selection of food based on individual needs of patients.
h. Accommodations for recreational and religious activities.
i. Adequate space for private small group interactions.
j. Retention and use of personal possessions as space and safety permits.
k. A telephone accessible to the patient.
l. Oxygen available to each patient as necessary.
m. The provision of either home health aide, license practical nurse or registered nurse to address the medical needs and ensure the safety and well being of patients on a 24-hour-a-day basis.
n. Routine and emergency drugs and biologicals.

I acknowledge that I have been given ample opportunity to ask any and all questions concerning the Residence and agree that I am responsible for payment to Hospice of Orleans for any services not covered by third party payors.

SIGNATURES

Applicant

_____	_____	_____
Printed Name	Signature	Date

Health Care Proxy

_____	_____	_____
Printed Name	Signature	Date

Power of Attorney

_____	_____	_____
Printed Name	Signature	Date

Hospice Witness

_____	_____	_____
Printed Name	Signature	Date

BILLING INFORMATION

Name: _____

Address: _____

City/Town: _____ State: _____ Zip Code:_____

Phone: _____ Alternate phone: _____

Lawyer Name: _____ Phone#: _____

Medicare (Check one)

___ YES

Medicare A Number: _____ Medicare B Number: _____

Medicare D Number: _____ Effective Date: _____

___ NO

Medicaid (must be approved nursing home coverage)

Check one: (if pending check no and give name of case worker)

___ YES

Medicaid Number: _____ Effective Date: _____

___ NO

Notes:

Commercial Insurance (Check one)

___ YES

Insurance Carrier Name: _____Insurance Carrier Number: _____

Insurance Carrier Telephone: _____ Policy Number: _____

Primary Insurer Name: _____ Effective Date: _____

___ NO

Private Pay

Financial Party Responsibility Name:

_____

Long Term Care Insurance

___ Yes

Name: _____

Policy Number: _____

___ NO

Copies of the following are required. Please mark those that are attached.

___ Power of Attorney ___ Medicare Card ___ Medicaid Card

___ Commercial Insurance Information ___ Advance payment (if applicable) ___ Bank & Investment Statements (3)

Charge Card Information

Type of Card:_____ Name on Card:_____

Charge Card #:_____ Expiration Date:_____ Sec Code:_____

I. APPLICANT DEMOGRAPHICS

1. NAME OF APPLICANT _____

2. HOME ADDRESS _____

CITY _____ STATE_____ ZIP_____

3. TELEPHONE NUMBER _____

4. SOCIAL SECURITY NUMBER _____

5. SEX_____ (F = Female, M = Male) 6. BIRTHDATE _____

7. MARITAL STATUS _____ (S = Single, M = Married W = Widowed, P = Separated, D = Divorced)

8. LOCATION OF APPLICANT _____

9. ANY PREVIOUS NURSING FACILITY STAY (Y/N) _____ IF YES,

FACILITY NAME _____ DATE _____
NAMI _____

II. RESPONSIBLE PERSONS

10. FINANCIAL REPRESENTATIVE (manages financial obligations for applicant)

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

PHONE: HOME _____ WORK _____ CELL _____

BANK POWER OF ATTORNEY (Y/N)_____ DURABLE POWER OF ATTORNEY (Y/N) _____

COMMITTEE OF ESTATE (Y/N) _____ CONSERVATORSHIP/GUARDIAN (Y/N) _____
PENDING (Y/N) _____

11. DESIGNATED REPRESENTATIVE (oversees needs of applicant)

NAME _____ RELATIONSHIP _____

ADDRESS _____

CITY_____ STATE_____ ZIP_____

PHONE: HOME _____ WORK _____ CELL _____

12. ATTENDING PHYSICIAN(S) ADDRESS TELEPHONE

_____

_____

Revised Date 06-21-16

III. STATEMENT OF RESOURCES

13 A. SALARY	APPLICANT	SPOUSE
B. SOCIAL SECURITY	$_____	$_____
C. RETIREMENT PENSION	$_____	$_____
D. VETERAN'S PENSION	$_____	$_____
E. OTHER (SPECIFY): _____	$_____	$_____

TOTAL MONTHLY INCOME $_____

COMMENTS: _____

14. ADDITIONAL ASSETS (TYPE: C = checking, S = savings, O = other assets such as stocks, bonds, etc.)

NAME/DESCRIPTION	TYPE	APPROXIMATE VALUE
_____		$_____
_____		$_____
_____		$_____
_____		$_____
	TOTAL ASSETS	$_____

15. ADDITIONAL INFORMATION:_____

IV. PLACEMENT PREFERENCES

1. _____
2. _____
3. _____
4. _____

COMMENTS_____

I ACKNOWLEDGE THAT THE INFORMATION PROVIDED WILL BE RELIED UPON IN MAKING A DECISION REGARDING ADMISSION.

SIGNATURE: _____ **SIGNATURE DATE:**_____

APPLICATIONS ARE ACCEPTED AND CONSIDERED WITHOUT REGARD TO RACE, CREED, COLOR, AGE, SEX, MARITAL STATUS, RELIGION, NATIONAL ORIGIN, SPONSOR, SEXUAL PREFERENCE, BLINDLESS, OR OTHER HANDICAP.

Routing

- **Social Worker, Admissions Nurse or Executive Director**
- **Finance Director or Executive Director**
- **Social Worker or Executive Director**
- **Finance Director**
- **Billing Clerk**