

MOUNT CARMEL
5700 West Layton Avenue - Greenfield, WI 53220
Phone: (414) 281-7200 Fax: (414) 281-4620

ADMISSION APPLICATION

GENERAL INFORMATION

Applicant's Name: _____ Telephone: _____

Home Address: _____

City/State/Zip: _____

Date of Birth: _____ Age: _____ Sex: _____ Race: _____

Birthplace/State: _____ County/Country: _____

U.S. Citizen: Yes: _____ No: _____

Religion: _____ Home Parish: _____ Phone #: _____

Does Applicant want Clergy informed they are at Mount Carmel? Yes: _____ No: _____

Marital Status: _____ Name of Spouse: _____

Deceased? Yes: _____ No: _____ Nursing Home? Yes: _____ No: _____

Living at home? Yes: _____ No: _____

Primary language spoken: _____

Was applicant in the U.S. Armed Forces? Yes: _____ No: _____ Dates of Service: _____

Army: Navy: Air Force: Marines: Coast Guard: National Guard:

Previous occupation: _____ Employed at: _____

Name of Applicant's parents: Mother's Maiden Name: _____ First: _____

Father's Last Name: _____ First Name: _____

Has Applicant been in a Skilled Nursing Facility (SNF) prior to this admission? Yes: _____ No: _____

Name of Facility: _____ Date - From/To: _____

Name of Facility: _____ Date - From/To: _____

Was Medicare billed for the previous SNF stay(s)? Yes: _____ No: _____

If yes, Medicare dates billed: Date - From/To: _____

Date - From/To: _____

Has Applicant been in the hospital in the last 60 days?

Hospital Name: _____

Dates - From: _____ Through: _____

CONFIDENTIAL INFORMATION

Has anyone been appointed Power of Attorney? Yes: ____ No: ____ Guardian? Yes: ____ No: ____

If yes, has the Power of Attorney been activated? Yes: ____ No: ____

FINANCIAL: If yes, who? _____ Relationship: _____

MEDICAL: If yes, who? _____ Relationship: _____

GENERAL INFORMATION (NOTE: Mount Carmel can only release information to those listed below).

I. A. Financial Responsibility

Name: _____ Relationship to Applicant: _____

Address: _____

City/State/Zip: _____

Telephone: Home: _____

Business: _____

Cell: _____

E-Mail: _____

B. Emergency Contact

Name: _____ Relationship to Applicant: _____

Address: _____

City/State/Zip: _____

Telephone: Home: _____

Business: _____

Cell: _____

E-Mail: _____

C. Secondary/Alternate contact in case of an emergency

Name: _____ Relationship to Applicant: _____

Address: _____

City/State/Zip: _____

Telephone: Home: _____

Business: _____

Cell: _____

E-Mail: _____

II. FINANCIAL INFORMATION

The information on this form ensures that there are funds available to care for the applicant. This information is also needed for all Residents regardless of pay type. Mount Carmel is Family Care provider. **All information given will be kept confidential.**

Medicare #: _____ A _____ B _____ SSN: _____

Medicaid (T-19) #: _____ Yes: _____ No: _____

If applying, who will complete the information? _____

If you are unsure or have questions, please contact our Business Office the next business day.

Do you have Family Care? Yes: _____ No: _____ Don't know: _____

Do you have I-Care? Yes: _____ No: _____ Don't know: _____

Do you have CCE? Yes: _____ No: _____ Don't know: _____

Case Manager: _____ Phone: _____

It is not necessary to disenroll from Family Care or CCE to be admitted to Mount Carmel.

Any other insurance that will cover nursing care? Yes: _____ No: _____

Name: _____ Policy #: _____ Group #: _____

Address/Phone: _____

SOURCES OF INCOME

Social Security	\$	SSI	\$
Veterans' Benefits	\$	Private Pension	\$
Railroad Benefits	\$	Other	\$

ASSETS

Cash on hand	\$	Certificated of Deposit (CD's)	\$
Checking	\$	Trust Fund Accounts	\$
Savings	\$	Paid up Life Insurance	\$
Value of Stock	\$	Paid up Burial Trust	\$
Value of Bonds	\$	Other	\$

Does Applicant own a home? Yes: _____ No: _____ Approximate Value: \$ _____

Is property owned jointly? Yes: _____ No: _____ Name of Co-owner: _____

Any other property owned? Yes: _____ No: _____ Approximate Value? \$ _____

Has the Applicant transferred, given away, or sold assets in the last 36 months? Yes: _____ No: _____

If yes, describe below:

Asset description: _____ Value: \$ _____

To whom: _____ When: _____

Asset description: _____ Value \$ _____

To whom: _____ When: _____

Family Physician: _____

Phone Number: _____

Will Physician continue to follow Applicant's care while at the facility?* Yes: _____ No: _____

(If the Applicant's Physician will not be following at Mount Carmel, we will assist in obtaining a Physician who will follow the applicant)

Have funeral arrangements been made? Yes: _____ No: _____

Funeral Home: _____

Address: _____

City/State/Zip: _____

Is Applicant a smoker? Yes: _____ No: _____

Please provide with this application, copies of the Applicant's:

- | | |
|--|--|
| <input type="checkbox"/> Birth Certificate | <input type="checkbox"/> Medication / Part D Card |
| <input type="checkbox"/> Social Security Card | <input type="checkbox"/> Medicaid |
| <input type="checkbox"/> Medicare Card | <input type="checkbox"/> Living Will |
| <input type="checkbox"/> Any Private Insurance Cards | |
| <input type="checkbox"/> Power of Attorney papers (POA) | |
| <input type="checkbox"/> Legal Guardianship papers | |

Office Use: BS: SSC: MC: PIC: POA: GP: M/PD: MCD: LW:

Does Applicant have a Transit Plus Card? Yes: _____ No: _____

I hear by state that to the best of my knowledge and belief, the above stated information is true, correct and complete. I understand that if any information has been falsely represented, this will be sufficient for voiding this application for admission. All of the information will be kept confidential by the nursing center and will not be released without written permission.

Applicant, POA or Legal Guardian: _____ Date: _____