Admission Application

Please fill out completely and send to Mayo either by email to ***admissions@mayohc.org****, uploading to our website at* ***https://mayohc.org/admissions****, or by mail to: Mayo Healthcare, Admissions, 71 Richardson Street, Northfield, Vermont 05663.*

How did you hear about Mayo? _____

Level of care desired? (Residential Care, Skilled Nursing, Rehabilitation) _____

What is your expected time frame for admission? _____

Resident's Name _____ Date _____

Birthdate _____ Age _____ Sex _____ Birthplace _____

Covid Vaccine Status _____

Address _____

City _____ State _____ Zip Code _____

How long at the above address? _____ Resident of _____

Social Security # _____ Medicaid # _____

Medicare # _____ part A _____ part B _____

Health Insurance _____

Policy # _____

Does resident have any other insurance that will cover cost? _____

Name of Policy _____

Policy # _____

Resident's marital status _____ Spouse's name _____

If Spouse is living: Spouse's address _____

Spouse's phone # _____

If resident has children or next of kin, please list with address and phone number on a separate sheet of paper and attach to the application.

Resident's past occupation _____

Resident's level of education _____

Resident's religion _____

Source of referral _____

Person the resident has appointed to act on their behalf as:

Healthcare POA _____

Financial POA _____

Legal Guardian _____

Responsible party and/or family member responsible for managing Resident's affairs

Name _____

Relationship to resident _____

Address _____

City _____ State _____ Zip Code _____

Telephone # (home) _____ (work) _____ (cell) _____

Email address _____

Occupation _____

Will this individual help defray cost of care? _____

Medical Information

Physician's name _____ phone # _____

Current medical problems:

Past medical problems:

Allergies (Food, Medications):

Resident's last hospitalization _____

Reason for admission _____

How long was resident hospitalized? _____

Has resident ever been in a nursing or residential care home? ☐ Yes ☐ No

If yes, give dates _____

Reason for stays _____

Reason for discharge _____

Mobility

Resident walks independently _____ with a walker _____ with a cane _____

Resident needs assistance when walking _____

Resident is not able to walk _____

Resident uses a wheelchair _____

Resident is independent in wheelchair _____ needs assistance in wheelchair _____

Resident is able to transfer self from bed to chair _____ needs assistance _____

Resident is bed bound _____

Dietary

Resident feeds self _____ needs assistance with feeding _____

Resident needs to be fed _____

Resident is on a regular diet _____ special diet _____

Appetite is good ☐ poor ☐ fair ☐

Food likes and dislikes:

Present weight _____ Normal lifetime weight _____

Has there been a recent weight loss ☐ or gain ☐ / how many pounds _____

Present height _____

Describe use of alcohol and tobacco _____

Resident's Care Needs

Is resident able to bathe self independently _____ needs assistance in bathing _____

Is resident able to dress self independently _____ needs assistance in dressing _____

Is resident able to toilet self _____ needs assistance getting on/off toilet _____

Is resident continent of bowel _____ of bladder _____

Does resident have incontinent episodes only at night _____ How often _____

Does resident wear Depends _____

Does resident take care of own Depends _____ needs assistance with Depends _____

History of constipation _____

History of urinary tract infections _____

Have there been any recent changes in care needs _____

Is resident presently receiving any assistance from agencies such as Home Health? _____

What agency is providing services? _____

How often does this agency provide services to resident? _____

What type of services are provided by outside agency _____

Does resident take medications on own ☐ needs to have medication administered ☐

Hearing: good ☐ poor ☐ wears hearing aid ☐

Vision: good ☐ poor ☐ wears glasses ☐ Last eye exam _____

Does resident wear dentures _____ upper ☐ lower ☐

Last dental exam _____

Does resident use oxygen _____ How much _____ How often _____

Sleep pattern: Sound sleeper _____

Up at night _____ how often _____

Naps for more than one hour during day _____

Mental Status

(Please check all that apply)

Orientated to Person _____ Time _____ Place _____

Forgetful _____ Difficulty expressing self _____

Episodes of delusional thinking _____ Paranoid _____

Wanders _____ At risk for wandering out of building _____

May wander into others' rooms _____

Generally quiet _____ Noisy _____

Easily agitated _____ Can be combative _____ Verbally abusive _____

Sociable _____ Withdrawn _____ Reclusive _____

Resists care _____ Generally cooperative _____

Depressed mood _____ Has been treated for depression in past _____

Is presently being treated for anxiety _____

Have there been any recent changes in mental status? _____

_____

Does resident accept need for placement? _____

Is religion important in resident's life? _____

How often does resident attend church services? _____

Would resident appreciate activities? _____

Please list hobbies or interests:

Does resident generally have regular hairdresser appointments? _____

How often? _____

Do you anticipate that resident will be able to return home at some point in the future? _____

Please use the remaining space to tell us anything else about the resident that would be helpful in the development of his/her individualized plan of care:

Prior to admission to Mayo Healthcare, Inc. the following will be required:

1) A completed application
2) A copy of potential resident's
   a. social security card
   b. Medicare card or copy of medical bill with Medicare number
   c. Health insurance/prescription card or copy of bill with insurance id#
3) A copy of Legal Guardianship (and/or) Power of attorney (in applicable)
4) Medical records from resident's primary care physician including:
   a. Current history and physical (physical exam must have been within three months prior to admission)
   b. Current medication orders
   c. Current diagnoses

Payment

Prior to, or on the day of admission, you should be prepared to pay for 60 days in advance. The first 30 days will be applied to the current room and board. The second 30 days payment will be kept in an interest bearing escrow account to apply to the last month's room and board. If you are being admitted to Mayo Rehabilitation and Continuing Care from the hospital after a 3 day qualifying stay, your stay at Mayo may be covered by Medicare for up to 100 days. Once Medicare coverage ends, you will be required to pay for 60 days in advance.

If you will be applying for Medicaid, you will receive the Medicaid application from the Admissions Coordinator upon admission.

_____

Signature of Resident or Financial POA/ Responsible party

Date _____

Please Be Aware Of Our Pharmacy Requirements
Mayo Rehabilitation and Continuing Care has contracted with **Pharmerica for Long Term Care Services** to supply and monitor all of our medications.

We do not accept medications from any other pharmacy. Pharmerica will bill private pay residents directly.
If you are being admitted to Mayo Residential Care, medications will be supplied by **Northfield Pharmacy**.

Please do not hesitate to call if you have any questions regarding our admission process.

Financial Information

Will the Resident pay for stay out of own funds? ☐ Yes ☐ No

Has the Resident applied or will they be applying for Medical Assistance (Medicaid)? ☐ Yes ☐ No

If Resident has applied, what was the date? _____ Where? _____

Does Resident have a Funeral Trust? ☐ Yes ☐ No

Funeral Service Provider _____ Phone# _____

All questions must be answered as completely and accurately as possible.

Cash Assets

(Please use additional sheet if necessary)

Bank: _____

Location: _____

Type of Account (checking, savings): _____

Balance in Account: _____

Real Estate Assets

(Please use additional sheet if necessary)

Does Resident own home? ☐ Yes ☐ No Approximate value _____

Does anyone live in the home? ☐ Yes ☐ No Relationship _____

Does Resident own any other property? ☐ Yes ☐ No

If yes, where is property located? _____

Does Resident receive any "rental" income? ☐ Yes ☐ No

How much per month? _____ Per Year? _____

Monthly Income Information

Social Security _____

Supplemental Security _____

VA Pension _____

Retirement Pension _____

Trust Fund _____

Rental _____

Other _____

Other Assets

Please list other assets and their value, such as stocks, bonds, life insurance with cash value, trust funds, certificates of deposit, etc.

Financial Information Concerning Sponsor

Will responsible party pay for the Resident's stay? ☐ Yes ☐ No

Will responsible party use Resident's assets towards resident's stay? ☐ Yes ☐ No

If responsible party will pay for the resident, then responsible party must answer questions as found in the Financial Information section of this application.

Authorization

I attest, under penalty and perjury that everything stated in this application is true and correct. I understand that Mayo Healthcare may check my bank references and credit history and I authorize this. I also understand that Mayo Healthcare considers this application as a continuing statement of financial condition and I agree to notify Mayo Healthcare in writing of any substantial changes in the above financial condition. All of this information will be kept strictly confidential by Mayo Healthcare. I agree that a photocopy shall have the full force and effect as the original of this application.

Date _____ Signature of Resident _____

Date _____ Signature of Responsible Party _____

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