Samaritan Health Center

The Fields of Washington Co.

Please print and completely fill out the application.
Mail to: Samaritan Campus
Admissions
531 E Washington St
West Bend WI 53095

Skilled Care ☐ *RCAC* ☐ *CBRF* ☐

Application Date:___________________

Last Name: ___________________________ First Name ______________________ MI _____

Name by which resident prefers to be addressed _________________________ Maiden Name _______________

Current Address: ______________________________City___________________State ______Zipcode____

County ____________________Phone #_____________ Marital Status: M__ D__ S__ W__ (If widowed date:_______)

DOB_________________ Age__________ Birthplace (city, state, county)__________________________________

Sex: M__F__ Race ______________Preferred Language ____________________________ U.S. Citizen Y___N___

Spouse Name _____________________________________ Phone #(H/C/W)_______________ DOB____________
(Last Name) (First Name) (MI) (Maiden) _______________

Spouse Address _________________________________City ________________State_________ Zip ___________

Is there a Power of Attorney for Health Care completed? Y____ N____ (**A copy is <u>required</u> on admission**)

Is there a Living Will? Y___ N___ (**A copy is <u>required</u> on admission)**

Is there a financial Power of Attorney completed? Y____ N _____ (**A copy is <u>required</u> on admission**)

Guardianship Y___ N___ Guardian Name: _______________**(A copy of guardianship papers required on admission)**

Protective Placement Y____ N____ **(A copy of Protective Placement is required on admission)**

Will be admitted from:____________________________________ Address: _______________________________

Military Service of applicant/spouse (include branch & date(s) of service)___________________________________

Past Occupation____ Year of Retirement_______________________

Education-(circle one) 8th grade or less; 9-11th grade; high school; trade school; college; other___________________

Financial Party____________________________ Relationship_____________ Phone (H)___________________

Address ___________________________City _______________State______ Zip ______ (C)___________________
(Financial Responsible) (W)___________________

Contact name for admission information and entry paperwork? Name ___________________ Phone_______________

INSURANCE INFORMATION

Social Security #: ____________________________ Medicare #: _______________________________________

Medicare HMO # ___________________________ **Part A:** Y___ N___ **Part B:** Y___ N___ **Part D:** Y___ N___

HMO Name ____________________________ Part D Name___________________ Effective Date ________

Medicaid (T19) #:_______________________

Family Care – Care Wisconsin ☐ Community Care ☐ Effective date:_______________

Case Worker ________________________ Phone # _____________________

Is there other Health Insurance or Supplement (AARP, BC/BS, WPS, Physician's Mutual, etc.) Y _____ N ______

If so, Name of insurance _____________________________ Policy Number(s)______________________________

PLEASE NOTE: COPIES OF MEDICARE, MEDICAID, FAMILY CARE, INSURANCE CARDS & SOCIAL SECURITY CARD MUST BE SUBMITTED <u>BEFORE</u> ENTRY DAY

Health Information

Is applicant currently in the hospital? Y ____ N____ Date Admitted to Hospital ______________________________

Name and address of hospital ____

Contact person ____ Current condition _______________________________

Has the applicant been hospitalized within the last 6 months? Y____ N ____ If yes, where and when? ____________

____

Prior Nursing Home or Subacute admissions? Y ____ N ____, If yes Name of facility ___________________________

Dates of stay(s) ____

Does applicant have a psychiatrist? Y ____ N ____, If yes, name ____

Personal Physician __________________________ Complete Address/Phone _____________________________________

Hospital Preference ________________________________ Where located ______________________________________

Eye Physician _______________________________ Complete Address/Phone __________________________________

Dentist ___________________________________ Complete Address/Phone _____________________________________

Podiatrist _________________________________ Complete Address/Phone ______________________________________

Audiologist _______________________________ Complete Address/Phone ______________________________________

If your physician does not practice at Samaritan will you transfer to a physician that does? Y___ N___
Will you transfer to a staff dentist? Y___ N____

Long term stay anticipated? Y___ N___ Anticipated length of stay _____________ Discharge plans? Y___ N___

Religion

Religion ______________ Church __________________________ Name of pastor or priest__________________________

Church – Complete Address/Phone ____

Funeral Info

Funeral home:____________________________ Complete Address/Phone ______________________________________

Do you have a burial trust established? Y ____ N ____ Cremation? Y____ N____

Burial plot: Name and location of cemetery ____

History

List residence(s) during the past 5 years. (List most recent first) ____

____

____

Are you currently receiving supportive services?

Senior Dining_____ Home Care_____ Lifeline_____ Other______________ Agency Name _________________

____

Please list, in order of preference, persons you wish to designate as contacts, check appropriate box(s) at right of each contact and sign at bottom:

1. Name ______ Relationship ______
   Address ______ Home Phone Number ______
   City/State/Zip ______ Cell/Work Phone Number ______

   Primary Contact For: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

2. Name ______ Relationship ______
   Address ______ Home Phone Number ______
   City/State/Zip ______ Cell/Work Phone Number ______

   Primary Contact For: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

3. Name ______ Relationship ______
   Address ______ Home Phone Number ______
   City/State/Zip ______ Cell/Work Phone Number ______

   Primary Contact For: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

4. Name ______ Relationship ______
   Address ______ Home Phone Number ______
   City/State/Zip ______ Cell/Work Phone Number ______

   Primary Contact For: Medical Issues ☐ Financial Issues ☐ Other Issues ☐

If the above person(s) cannot be contacted, who else could be notified?

Name ______ Relationship ______
Address ______ Home Phone Number ______
City/State/Zip ______ Cell/Work Phone Number ______

Please use another sheet to list other children or contact persons (if applicable).

Signature Required Below:

I, (Patient/Legally Authorized Rep) ______________________, authorize Samaritan
(Signature of Patient or Guardian/Activated POA/HC)
Health Center / Fields of Washington County to notify any one of the parties designated above in the event of accident, injury or adverse change in my condition and/or to discuss any protected/personal health information regarding my care.

I further authorize Samaritan Health Center / Fields of Washington County to notify any one of the parties designated above of any changes in status to include plans for discharge, room changes, and transfer to another facility and/or financial matters.

MAIL

Residents have the right to send and receive their mail unopened. It is understood that the resident may request assistance from Samaritan Campus staff in opening their personal mail at any time. If, for any reason, staff believes the resident is no longer able to open and handle the personal mail, the personal representative will be notified.

Please direct Samaritan Campus as to the disposition of the mail by checking the appropriate choice(s) below and filling in any associated blank lines.

_____ All personal and business mail should be given to resident/tenant directly

_____ All personal mail should be given to resident/tenant directly and business mail should be directed to

____

(Name of person to receive business mail must be listed on this line)

_____ All personal and business mail should be directed to _________________________

(Name of person to receive personal and business mail must be listed on this line)

_____ If resident is unable to open mail (i.e. personal, checks for payment, Medicare, Medical Assistance, and private insurance, etc.), permission is given for Samaritan Campus staff to help resident open their mail.

LAUNDRY

Resident/Tenant requests laundry is done by (please check choice below):

______ Resident's Family

______ Samaritan Campus Laundry Fee $________________/load for personal clothes

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Shopping/Appointments

Who will assist with shopping errands as needed? ________________________________

Who will assist with doctor appointments? ______________________________________

ALL APPLICANTS

I certify the information in this application is true to the best of my ability. The undersigned hereby applies for admission and agrees, if admitted, to comply with all current and future policies and procedures.

_______________________________ _______________________

Signature of Applicant Date

_______________________________ _______________________

Signature of Responsible Party Date

____

Relationship to Applicant

Samaritan Campus
Pre-Admission Confidential Financial Statement

Applicant's Name ______________________________Phone #__________________________________

Complete Address____

Own home_________Rent_________

PRIVATE RESOURCES	**Applicant**	**Spouse**
Social Security Benefits	$________(Direct deposit)Y___N___	$________________
Real Estate – approximate value	$__________________	$________________
Cash Assets – approximate value	$__________________	$________________
Investments – approximate value	$__________________	$________________
Life Insurance – approximate value	$__________________	$________________
Burial Trusts – approximate value	$__________________	$________________
Other income (pension, Veteran's benefits, etc)	$________________	$________________
	$__________________	$________________
	$__________________	$________________

Is there a financial power of attorney? Y ___ N ___ Name ______________________ Phone#______________

List any unpaid bills, mortgages, loans, etc. that would reduce the applicant's fund for payment of Health Center care:

__________________________________	$_______________	$________________
__________________________________	$_______________	$________________
__________________________________	$_______________	$________________

State length of time applicant has sufficient funds to pay for care. Month's ______________________

Who will be assisting the resident if Medical Assistance is necessary?
Name____________________________ Phone #(h)________________________(c)____________________

I certify that the above information, to the best of my knowledge, is accurate and correct. I understand that Samaritan Health Center will hold the above information in strict confidence, and will release it only where authorized by law or required to collect this account.

____
Signature of person completing application

____
Relationship to applicant

Date_______________________ Application and content accepted by _________________________
(Admissions)

PLEASE NOTE:

Required with completed application:

- **$2,000.00 Security Deposit for The Fields RCAC & CBRF**

REMINDER

The following copies should be submitted with application, if applicable:

- **Durable Power of Attorney for Health Care**
- **Living Will**
- **Durable Power of Attorney for Financial**
- **Guardianship**
- **Protective Placement**
- **Medicare Card**
- **Medicaid Card**
- **Health Insurance Card(s)**
- **Social Security Card**
- **Family Care Paperwork**

Did someone recommend Samaritan Campus?

Friend_____ Family_____ Staff_____ Physician_____ Other_______

If not, how did you hear about the Samaritan Campus? ________________________________

Samaritan Health Care

531 E Washington Street
West Bend WI 53095
262-335-4500
Fax 262-335-4699

The Fields of Washington County - CBRF

531 E Washington Street
West Bend WI 53095
262-365-6500
Fax 262-365-6505

The Fields of Washington County - RCAC

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262-365-6500
Fax 262-365-6505

Website: www.co.washington.wi.us