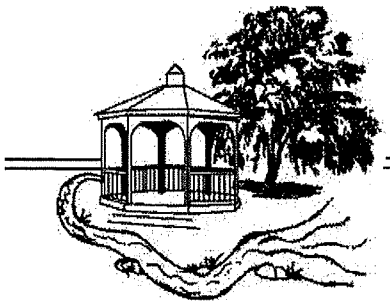

COUNTY OF NORTHAMPTON

DEPARTMENT OF HUMAN SERVICES

GRACEDALE NURSING HOME
Jennifer Stewart-King, NHA
Administrator
2 GRACEDALE AVENUE
NAZARETH, PENNSYLVANIA 18064-8785
610.829.3400 Fax 610.746.1901
Fax 610.746.1929 (Medical Only)
www.gracedale.org

Dear Applicant:

Whether you are looking for Short Term Rehabilitation, Long Term or Respite Care, we here at Gracedale are here for your needs. We are here to help you through this process which can seem challenging and overwhelming.

Enclosed please find the application for admission to Gracedale Nursing Home as well as a list of documents that are needed. Once you receive the application and gather the necessary paperwork give us a call and we can schedule you to come in to sign consents and, if needed, meet with the Business Office. Here at Gracedale we accept Medical Assistance and a large variety of insurances.

If the applicant is in the hospital please notify their Case Manager to fax us the medical records as soon as possible. If they happen to be at home or assisted living, please have their Primary Care Physician fax us records and complete a Medical Evaluation that will accompany the application from Gracedale (we do need the original back).

All Stays require current copies of Medical Records including, but not limited to history and physical, current medication list, labs, and any surgeries.

Please do not hesitate to call with any questions or concerns. The direct number is 610-829-3626 and the fax is 610-746-5208.

Sincerely,

ADMISSION DEPARTMENT

GRACEDALE ADMISSION APPLICATION
2 Gracedale Avenue
Nazareth, Pennsylvania 18064
Phone: 610-829-3600 Fax: 610-746-5208

Name of Applicant _____ Birth Place_____

Applicant Home Address _____

Since: _____Home phone: _____Current location: _____

Marital Status: _____ DOB: _____ Education: _____ US Citizen: YES or No

Past Employment: _____ Hospital Preference: _____

Primary Care Physician: _____ Prior Hospital or Nursing Home Stays: _____

Do you own your own home: YES or NO Mortgage Amount: _____ Value: _____

Veteran (Self or Spouse) Branch: _____ Dates of Service: _____

Registered Voter: YES or NO Religion: _____ Church: _____

Social Security #: _____ Medicare #: _____

Other Medical Insurance: _____ HMO: YES or NO

ID #: _____Group #: _____ Plan #:_____

Access Card (Medical Assistance) Recipient #:_____

PACE Card #: _____Expiration Date: _____ Medicare Part D: _____

Prescription Drug Plan: _____ Group and ID #'s: _____

Monthly Income: _____ Source: _____ Other Income: _____

Current Balance: Checking Acct: _____ Savings Acct: _____ Other: _____

CD's: _____ Stocks/Bonds/Annuities: _____ Trust Acct: _____

Unpaid Nursing Home Balance: _____ Loans: _____

Life Insurance Policies: Company: _____ Policy Number: _____

Face Value: _____ Cash Value: _____

Have you ever been convicted of a crime? YES or NO. If yes, please explain: _____

_____

Have any property or assets been liquidated within the past 5 years? YES or NO

This includes any gifts, donations, transfers, withdrawals, or transactions. If yes, please explain:

_____

Preferred Funeral Director and #: _____

Is this Prepaid: YES or NO Burial Plot: YES or NO Location: _____

Any Living Will/Advanced Directives: YES or NO

Any Power of Attorney (POA): YES or NO Name: _____

First Contact: Relation: _____

Name: _____

Address: _____

Phone: (H) _____ (C) _____

Email: _____

Second Contact: Relation: _____

Name: _____

Address: _____

Phone: (H) _____ (C) _____

Email: _____

I affirm that the information provided in this application, to the best of knowledge, is correct:

Applicant: _____ Date: _____

Resp. Party: _____ Date: _____

Influenza Vaccine: _____ Glasses: _____

Pneumonia Vaccine: _____ Hearing Aides: _____

COVID Vaccine: _____ Pacemaker: _____

Dentures: _____

Functional Status: _____

Allergies: _____

Gracedale Documents for Admission

All Stays require current copies of Medical Records including but not limited to History and Physical, current medication list, include labs and any surgeries

Short-Term Stay with Co-Insurance:

- Copies of Medicare, Insurance Cards, and Prescription Cards
- Any Power of Attorney or Living Will

Short-Term without Co-Insurance, Long-Term and Private Pay:

- Proof of Age: Birth Certificate or Driver's License
- I.D. Cards: Social Security, Medicare, Access, PACE, Blue Cross, Managed Care cards and Prescription cards
- Verification of Income: Copy of check, Pay Stub, or bank statement showing direct deposit
- The most recent financial Statements: Checking, savings, credit union, stocks, money market funds, annuities. List of CD's and savings bonds
- 1099 from all pensions (should be with tax records)
- Copy of any prepaid funeral arrangements or cemetery plot deed

Guardianship papers, Power of Attorney, Living Will

MEDICAL EVALUATION ☐ NEW ☐ UPDATED

1. MA RECIPIENT NUMBER	2. NAME OF APPLICANT (Last, first, middle initial)	3. SOCIAL SECURITY NO.	4. BIRTHDATE

5. AGE	6. SEX	7. ATTENDING PHYSICIAN	8. PHYSICIAN LICENSE NUMBER

9. EVALUATION AT (Description and code)

01 Hospital
02 NF
03 Personal Care/Dom Care
04 Own House/Apartment
05 Other (Specify) _____

10. For the purpose of determining my need for TITLE XIX INPATIENT CARE, Home and Community Based Services, and if applicable, my need for a shelter deduction, I authorize the release of any medical information by the physician to the county assistance office, Pennsylvania Department of Human Services or its agents.

SIGNATURE - APPLICANT OR PERSON ACTING FOR APPLICANT _____ DATE _____

11. HEIGHT	WEIGHT	BLOOD PRESSURE	TEMPERATURE	PULSE RATE	CARDIAC RHYTHM

12. MEDICAL SUMMARY

13. IN EVENT OF AN EMERGENCY THE PATIENT CAN VACATE THE BUILDING
☐ 1. Independently ☐ 2. With Minimal Assistance ☐ 3. With Total Assistance

14. PATIENT IS CAPABLE OF ADMINISTERING HIS/HER OWN MEDICATIONS
☐ 1. Self ☐ 2. Under Supervision ☐ 3. No

15. ICD DIAGNOSTIC CODES

PRIMARY (Principal)
SECONDARY
TERTIARY

16. PROFESSIONAL AND TECHNICAL CARE NEEDED - CHECK ✓ EACH CATEGORY THAT IS APPLICABLE

☐ Physical Therapy ☐ Speech Therapy ☐ Occupational Therapy ☐ Inhalation Therapy ☐ Special Dressings ☐ Irrigations
☐ Special Skin Care ☐ Parenteral Fluids ☐ Suctioning ☐ Other (Specify) _____

17. PHYSICIAN ORDERS

Medications _____
Treatment _____
Rehabilitative and Restorative Services _____
Therapies _____
Diet _____
Activities _____
Social Services _____
Special Procedures for Health and Safety or to Meet Objectives _____

18. PROGNOSIS - CHECK ✓ ONLY ONE
☐ 1. Stable ☐ 2. Improving ☐ 3. Deteriorating

19. REHABILITATION POTENTIAL - CHECK ✓ ONLY ONE
☐ 1. Good ☐ 2. Limited ☐ 3. Poor

20A **PHYSICIAN'S RECOMMENDATION** To the best of my knowledge, the patient's medical condition and related needs are essentially as indicated above. I recommend that the services and care to meet these needs can be provided at the level of care indicated - check ✓ only one

☐ Nursing Facility Clinically Eligible Services to be provided at home or in a nursing facility
☐ Personal Care Home Services provided in a Personal Care Home
☐ ICF/ID Care Services to be provided at home or in an intermediate care facility for the intellectually disabled
☐ ICF/ORC Care Services to be provided at home or in an intermediate care facility for consumers with ORCs
☐ Inpatient Psychiatric Care
☐ Other (Please Specify) _____

20B. **COMPLETE ONLY IF CONSUMER IS NURSING FACILITY CLINICALLY ELIGIBLE AND WILL BE SERVED IN A NURSING FACILITY.**

ON THE BASIS OF PRESENT MEDICAL FINDINGS THE PATIENT MAY EVENTUALLY RETURN HOME OR BE DISCHARGED. ☐ YES ☐ NO If Yes, Check ✓ Only One ☐ 1. Within 180 days ☐ 2. Over 180 days

20C. **PHYSICIAN'S SIGNATURE**

PHYSICIAN (PRINTED NAME) _____ TELEPHONE _____ PHYSICIAN SIGNATURE _____ DATE _____

FOR DEPARTMENT USE Medical and other professional personnel of the Medicaid agency or its designee MUST evaluate each applicant's or recipient's need for admission by reviewing and assessing the evaluations required by regulations.

21 **MEDICALLY ELIGIBLE** ☐ Yes ☐ No

22 **Comments. Attach a separate sheet if additional comments are necessary.**

REVIEWER'S SIGNATURE AND TITLE _____ DATE _____

ORIGINAL TO CAO - RETAIN PHOTOCOPY FOR YOUR FILE