Residency Application for Birchaven Heights

PERSONAL INFORMATION

Applicant's Full Name: ______________________________

Address: ______________________________

City ______ State ______ Zip Code ______

Telephone Number ______ Date of Birth ______ Social Security Number ______

Birthplace: ______ City ______ State   County of Residence: ______   How Long: ______

Occupation (previous if applicable): ______________________________ ☐ Retired

Military Service: ☐ Yes ☐ No   Branch of Service: ______________________________

Marital Status (check one): ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse's Name ______ Date of Birth ______ Social Security Number ______

Anniversary Date: ______________________________

VITAL STATISTICS

Height: ______ ' ______ "   Weight: ______ #   Hair Color: ______

Eye Color: ______   Language Spoken: ______   Race: ______   Sex: M / F

FINANCIAL REPRESENTATIVE: Personal/business to receive monthly bills IF other than self.

Name: ______________________________   Business: ______________________________

Address: ______________________________

City ______ State ______ Zip Code ______

Telephone: Home Number: ( ) ______   Business Number: ( ) ______

FAMILY INFORMATION

NEXT OF KIN: Children or other family members, friends, trust officers, attorneys in sequence to be notified in case of emergency.

1ST CONTACT

Name: ______________________ Relationship: ______________________

Address: ____

______________________ ______________________ ____________
City State Zip Code

Telephone: Home Number: (____) ______________ Business Number: (____) ______________

2ND CONTACT

Name: ______________________ Relationship: ______________________

Address: ____

______________________ ______________________ ____________
City State Zip Code

Telephone: Home Number: (____) ______________ Business Number: (____) ______________

3RD CONTACT

Name: ______________________ Relationship: ______________________

Address: ____

______________________ ______________________ ____________
City State Zip Code

Telephone: Home Number: (____) ______________ Business Number: (____) ______________

HEALTH INSURANCES (use seperate sheet for spouse)

List health and prescription drug insurance: provide copies of the front and back of all health and insurance cards.

Long term care: ☐ Yes ☐ No Company:________________ Policy #:________________________

Medicare: ☐ Yes ☐ No Plan A Policy #:________________ Plan B Policy #:__________________

Hospital: ☐ Yes ☐ No Company:________________ Policy #:________________________

Prescription drug: ☐ Yes ☐ No Company:________________ Policy #:________________________

HMO's or others:____ Policy #:________________________

Dates and nature of any major illnesses or operations: ____

____

Dates and nature of any mental or emotional illnesses: ____

____

**A complete Application for Admission must also include a history and physical form completed and signed by a physician no more than thirty (30) days prior to admission.*

PHYSICIANS (use seperate sheet for spouse)

FAMILY PHYSICIAN:___________________________________ Provider Number: ______________________

Address:__________________________ City:________________ State:______ Zip Code:___________

Telephone Number: (_____) _________________________________ Date of last visit:_________________________

Preferred Hospital:____

(in case of emergency, the ambulance will use closest facility, which is Blanchard Valley Hospital)

DENTIST:___________________________________ Provider Number: ______________________________

Address:__________________________ City:________________ State:______ Zip Code:___________

Telephone Number: (_____) _________________________________ Date of last visit:_________________________

EYE DOCTOR:___________________________________ Provider Number: ___________________________

Address:__________________________ City:________________ State:______ Zip Code:___________

Telephone Number: (_____) _________________________________ Date of last visit:_________________________

PODIATRIST:___________________________________ Provider Number:____________________________

Address:__________________________ City:________________ State:______ Zip Code:___________

Telephone Number: (_____) _________________________________ Date of last visit:_________________________

FINANCIAL DISCLOSURE

Your financial statement is reviewed on an annual basis by the administrative staff of Birchaven Heights. The review will be used for internal purposes only and to satisfy that your resources are sufficient to cover the cost of your services and to assure undue financial hardship is not caused through the charge structure. Birchaven Heights considers your age, health, and financial status carefully before making any decisions regarding your residency to Birchaven Heights. It is necessary that your provide an accurate account of your finances. **The information is retained in the strictest of confidence.**

INCOME

	Description and/or Source	Amount per Year
Pension	______________________	$ ______________________
	______________________	$ ______________________
Savings	______________________	$ ______________________
	______________________	$ ______________________
Checkings	______________________	$ ______________________
	______________________	$ ______________________
Social Security	______________________	$ ______________________
Trusts	______________________	$ ______________________
Other	______________________	$ ______________________
Rental Income	______________________	$ ______________________

Other properties or property rights not listed.:

	______________________	$ ______________________
	______________________	$ ______________________

LIABILITIES

	Description and/or Source	Amount per Year
Mortgage	______________________	$ ______________________
Note or Loans	______________________	$ ______________________
	______________________	$ ______________________

Have you transferred assets over $10,000 to anyone or to any institution in the last sixty (60) months?

☐ Yes ☐ No

If yes, what amount was transferred?:__________________________ To whom?:____________________

Birchaven reserves the right to request copies of two of your most recent 1040 IRS forms (if you still file) and proof of assets, such as copies of bank statements, certificates of deposit, etc.

Life Insurance Company Name and Policy Numbers

Applicant	____________________	$ ____________________
	____________________	$ ____________________
Spouse	____________________	$ ____________________
	____________________	$ ____________________

ADVANCE DIRECTIVES FOR HEALTH CARE

List any Advance Directives for Health Care that you may have made. ***This is not an authorization to implement any Advance Directives.*** Provide a copy of any or all that apply.

☐ Living Will ☐ Do Not Resuscitate ☐ Organ Donor ☐ Autopsy ☐ Durable Power of Attorney for Health Care

Comments: ____________________

SPIRITUAL LIFE

Name of Church: ____________________

Address: ____________________

City: ____________________ State: ____________________ Zip Code: ____________________

Minister: ____________________ Church Phone: (____) ____________________

FINAL PLANS

Describe funeral plans. Funeral home must be identified even if no contract exists.

Pre-paid funeral plans: ☐ Yes ☐ No Company: ____________________

Policy Number: ____________________

Place of Internment: ____________________ City: ____________________ State: ____________________

Funeral Home: ____________________

City: ____________________ State: ____________________ Telephone Number: (____) ____________________

ACCOMODATIONS REQUESTED

Please indicate first, second, and third choice.

Apartments:

_____ 1-Bedroom	_____ 2-Bedroom
_____ 1-Bedroom Patio/Balcony	_____ 2-Bedroom Patio/Balcony
_____ 1-Bedroom Turret	_____ 2-Bedroom Turret
_____ One Bedroom First Available	_____ Two Bedroom First Available

Reservation deposit: $1,500 for 1-bedroom and $2,000 for 2-Bedroom due upon acceptance of specified apartment.

When moving from a 1-bedroom to a 2-bedroom, or vice versa, the security deposit will be adjusted accordingly.

RELEASE OF MEDICAL RECORDS

I authorize the release of my medical record to Birchaven Heights from my physicians, hospital, and health care agencies for the purpose of Birchaven Heights' review and processing of my residency application.

______________________________ ______________________________

Name Date

I HEREBY CERTIFY that I make this application of my own free will. It is my purpose to make Birchaven Heights my home. In completing the foregoing Residency Application, I declare that all statements made herein are true, full, and complete to the best of my knowledge.

______________________________ ______________________________

Signature of Applicant Date

______________________________ ______________________________

Signature of Co-Applicant/Spouse Date

I, the undersigned Sponsor, interested in the applicant's residency have advised the applicant to sign it, and it was signed in my presence of the applicant's own free will.

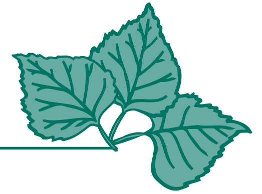
______________________________ ______________________________

Signature of Sponsor Date

Copies of:
- ☐ Insurance Cards
- ☐ Advance Directives
- ☐ Organ Donor
- ☐ Living Will
- ☐ POA

Move-In Date: ______________ Apt. #: __________

Resident Rights



The following rights are inherent to all residents of Birchaven and must be respected and observed by all staff members, volunteers, government agents, visitors and residents.

1. The right to a safe and pleasant living environment.

2. The right to be treated with courtesy, respect, and full recognition of dignity and individuality.

3. The right to the most appropriate medical and nursing treatment available and to other services which comprise the care covered by Birchaven's rate, without regard to consideration of such as race, color, religion, national origin, handicap, age or source of payment for care.

4. The right to have clean and neat clothing, bedding and personal effects.

5. The right of privacy during medical examination, treatment and care of personal or bodily needs.

6. The right to be free from all chemical and physical restraints. Birchaven is a "restraint free" facility. Restraints will not be used except for the client's personal safety and only as authorized in writing by the attending physician for a specified and limited period of time (not to exceed 30 days) and documented in the resident's medical record. Restraints may not be used for staff convenience.

7. The right to exercise all civil rights, unless the resident has been adjudicated incompetent and has not been restored to legal capacity, including but not limited to the right to acquire and dispose of property, to execute instruments, and to vote, as well as the right to the cooperation of the facility's staff in making the necessary arrangements for the exercise of these civil rights.

8. The right to consume a reasonable amount of alcoholic beverages at his/her own expense, unless not medically advisable as documented in the medical record by a physician.

9. Birchaven is a smoke free facility. Residents (as well as visitors and employees) do not have the right to use tobacco within the facility.

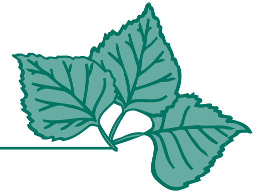
10. The right to retire and rise in accordance with his/her personal wishes, provided that he/she does not disturb others, unless not medically advisable as documented in the medical record by a physician.

11. The right to maintain individual and cultural identity, to observe religious obligations, and to meet or refuse to meet with and participate in activities of social, religious, and community groups at the resident or the group's initiative, unless not medically advisable as documented in the medical record by a physician.

12. The right to privacy for visits by the spouse, or if both are residents of Birchaven, the right to share a room, unless not medically advisable as documented in the medical record by a physician.

13. The right to mentally and socially compatible roommates within the capacity of Birchaven.

Resident Rights *(continued)*



14. The right, upon request, to have room doors closed and not have them opened without knocking, except in the case of an emergency.

15. The right to retain and use personal clothing and possessions, as space permits, in a reasonable, secure manner unless to do so would infringe upon the rights of other residents, and unless not medically advisable as documented in the medical record by a physician.

16. The right of the resident or sponsor having legal right to property to be allowed unrestricted access to his/her property on deposit at reasonable hours.

All of the following rights shall be enforceable by the resident's sponsor when:

(a) A resident is adjudicated incompetent pursuant to chapter 2111. of the Ohio Revised Code.

(b) A resident is found by a physician to be medically incapable of understanding these rights, and it is so documented in the medical record by a physician.

17. The right to have all reasonable requests and inquiries responded to promptly and adequately within the capacity of the home.

18. The right to obtain from the facility the name and specialty of the physician or other person responsible for the resident's care or for the coordination of care.

19. The right to a physician of the resident's choice at his/her own expense or under a health care plan within the capacity of the home.

20. The right to obtain from the attending physician complete and current information concerning medical condition, prognosis and treatment plan, in terms the resident can reasonably be expected to understand. The right of access to all information in the medical record. The right to give or withhold informed consent for treatment after the implications of that choice have been carefully explained. When it is not medically advisable to give such information to the resident, the information shall be made available to the sponsor on the resident's behalf.

21. The right to participate in the planning of his/her treatment or plan of care.

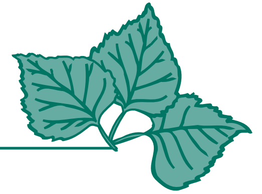
22. The right to be informed of an accident; any significant change in his/her physical, mental or psychosocial status; a need to alter treatment significantly; a decision to transfer or discharge; or a change in room or roommate and have this reported to his/her sponsor within 24 hours.

23. The right to withhold or refuse payment for any services not requested or received.

24. The right under the guaranteed services program to receive a money back payment for any service that does not meet the resident's or their family's satisfaction, see our guarantee to you.

25. The right to confidential treatment of personal and medical records, and the right to approve or refuse the release of these records to anyone outside the home, except in case of transfer to another health care facility as required by law, or as required by a third-party payment contract.

Resident Rights *(continued)*



26. The right to refuse, without jeopardizing access to appropriate medical care, to serve as a medical research subject.

27. The right to refuse to perform services for the facility.

28. The right to choose a pharmacist at his/her own expense or under a health care plan within the capacity of the facility. The facility has a contract with a pharmacy for a "unit dose medication system." Residents who do not choose this arrangement will be billed a small\monthly pharmacy service charge.

29. The right to private and unrestricted communications with his/her family, physician, attorney, social worker and any other person, unless not medically advisable as documented in the medical record by the attending physician, except that communications with public officials or with his or her attorney shall not be restricted in any event. Private and unrestricted communications shall include, but are not limited to, the right to:

    (a) Receive, send and mail sealed unopened correspondence.

    (b) Access to a telephone for private communications.

    (c) Private visits at any reasonable hour.

    (d) Assistance of a foreign language or sign language interpreter for the hearing impaired.

30. The right to be fully informed prior to or at the time of admission and during his/her stay, in writing, of services available in the home and of related charges, including charges for services not covered under Titles XVIII and XIX of the "Social Security Act," or under the basic per diem rate.

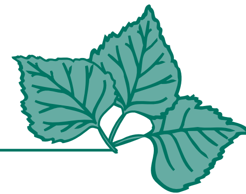
31. The right to examine, and receive an explanation of, an itemized monthly bill for his/her care by the home, regardless of the source of payment.

32. The right to manage his/her own personal financial affairs or, should the home accept written delegation of this responsibility, to obtain full and complete financial details, and receive a least a quarterly accounting statement of all financial transactions made on his/her behalf. Resident personal funds deposited with Birchaven will be kept in a separate account established solely for use by the residents and will not be commingled with facility funds.

33. The right to be transferred or discharged only for medical reasons; or for his/her welfare or that of another resident's; or for non-payment of stay, including after due notice, of termination of third party payment contracts except as prohibited by Titles XVIII or XIX of the "Social Security Act."

34. The right to voice grievances and recommend changes in policies and services to the home, to the staff, to the Resident Council, to the staff of the Ohio Commission on Aging, to Surveyors from the Ohio Health Department, or to other outside representatives of the resident's choice, free from restraint, interference, coercion, discrimination or reprisal. This right shall include the Resident Rights set out in the written policies of the home.

Resident Rights *(continued)*



PUBLIC INFORMATION

The following information is available for review upon request to all persons. Any person desiring to review any of the following material should notify the business office for an appointment indicating what material they wish to see and if they desire any staff assistance. Although the material cannot be removed from the facility, copies will be made upon request for a nominal charge per page.

l) Inspection reports for the past three years.

2) Nursing and Rest Home Laws and Rules, Ohio Department of Health.

3) Life Safety Code

The facility maintains a library of other information relative to long term care that is available upon request.

The following Resident Rights Advocates can provide additional information:

OHIO DEPARTMENT OF AGING
50 W. Broad Street, 9th Floor
Columbus, OH 43266
Phone 800.282.1206

HANCOCK COUNTY DEPARTMENT OF HUMAN SERVICES
1624 Tiffin Avenue
Findlay, OH 45840
Phone 419.422.0182

OHIO DEPARTMENT OF HEALTH
Northwest District Office
Toledo Government Center 13th Floor
Toledo, OH 43606
Phone 419.245.2840

SENECA COUNTY DEPARTMENT OF HUMAN SERVICES
3362 S. Eden Twp. Road 151
Tiffin, OH 44883
Phone 419.447.5011

OHIO DEPARTMENT OF HEALTH
246 North High Street
Columbus, OH 43266
Phone 614.466.2070

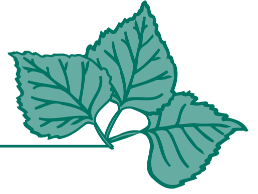
WOOD COUNTY DEPARTMENT OF HUMAN SERVICES
1928 E. Gypsy Lane Road
Bowling Green, OH 43402
Phone 419.352.7566

PSA # 3 AGENCY ON AGING
311 East Market Street, Suite 201
Lima, OH 45801
Phone 800.653.7778

OHIO DEPT. OF HUMAN SERVICE
Division of Medical Assistance
30 East Broad Street, 33rd Floor
Columbus, OH 43266
Phone 614.466.9243

REGIONAL OMBUDSMAN PROGRAM
3103 W. Elm St.
Lima, OH 45805
Phone 800.653.7778 OR 419.222.0563

Admission Releases



RELEASE OF MEDICAL INFORMATION

The undersigned authorizes the release of medical information to providers of medical service.

____ YES ____ NO

RELEASE OF RESPONSIBILITY OF ACTIVITIES PROGRAM

The undersigned releases Birchaven, its owners and employees from any/all responsibility for any accidents/ injury incurred within the community or while participating in any activity group outside the community.

____ YES ____ NO

ADVANCED DIRECTIVES

I have received information about advanced directives and understand my rights under Ohio Law.

I do__ or do not__ have Advanced Directives.

My Advanced Directives consist of the following:

DO NOT RESUSCITATE ___

DURABLE POWER OF ATTORNEY FOR HEALTH CARE___

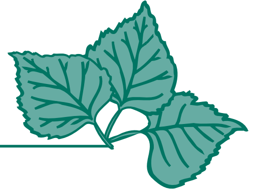
LIVING WILL____

Initials _______

_______________________________ (Client's Signature)

_______________ (Date)

Health Information



Name ______________________________ Date of Birth ____/____/_______

Address ____

Phone _____-_____-________

Physician's Name ____________________________ Physician Phone _____-_____-________

Specialty Physicians, Opthamologist, Dentist, Etc.

____

Health History: ____

____

____

____

____

Current Medical Diagnosis: ____

____

Allergies: ____

____

Medications: (This includes over-the-counter medications.)

______________________________ ______________________________ ______________________________

______________________________ ______________________________ ______________________________

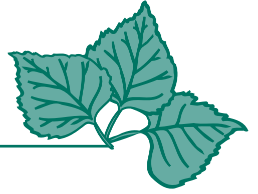
______________________________ ______________________________ ______________________________

DIET:____

____

____

Checklist For Apartment Clients



1. ☐ Copy of Medicare cards

2. ☐ Copy of insurance cards

3. ☐ Copy of prescription cards

4. ☐ DPOA / advance directives / living will

5. ☐ Code status __________ full code ________ no code

6. ☐ Allergies

7. Choice of funeral home/arrangements____

Emergency contact phone numbers

1. Name_____________________________ Home Phone_________________ Work Phone__________________

2. Name______________________________ Home Phone_________________ Work Phone__________________