THE
University of Vermont
HEALTH NETWORK

Alice Hyde Medical Center

# THE ALICE CENTER

Dear Applicant,

Thank you for your interest in The Alice Center. As part of the application process we need to have the following documents forwarded to us:

- PRI
- SCREEN
- Application for Nursing Home Admission
- Current List of Medications
- History & Physical

**PRI and SCREEN:** If you are currently in the hospital, you can ask the person who takes care of discharges to have these forms completed and forwarded to us. If you are at home, you can contact the Franklin County Public Health (518-481-1709) to have this done.

**Application:** Please complete the application included in this packet.

**Current List of Medications:** List of medications you are currently on and the frequency.

**History & Physical:** This is only necessary if you are already in a facility.

Upon receipt of the above information, your name will be added to the waiting pool. Please be aware that you must qualify in terms of the level of care needed in order to be admitted to our Center.

If you have any questions, please contact our Social Services department at 518-481-8006/8007. We thank you again for your interest in our nursing home.

THE University of Vermont HEALTH NETWORK
Alice Hyde Medical Center
THE ALICE CENTER

# Application for the Alice Center

Date:_____

Applicant's Name: _____
Last First Middle Initial

DOB:_____

Home Address: _____
City State Zip

The Applicant and Agents confirm that they have provided the Facility, on this application, a complete list of the Applicant's current Financial Agents, and all Powers of Attorney, Guardianship Commissions or other documents authorizing an agent to act for the Applicant or to have access to or control of any applicant's assets, e.g. access to joint ownership of bank accounts, stocks, or Social Security. Furthermore, they agree to inform the Facility of any future appointments or revocations immediately.

Initials:_____

## Health Insurance Information

Social Security number must be available upon request to verify insurance coverage.

Medicare#:_____ ☐ Part A ☐ Part B ☐ Part C

☐ Medicare PartD – Prescription Plan:_____

Has Medicaid Application been made: ☐ Yes ☐ No If yes, when?_____

Medical Insurance:_____

Long–Term Care Insurance:_____

Primary Care Physician:_____

Application for The Alice Center

The Applicant, or the legal representative of the Applicant, hereby directs all the Applicant's Agents, includingfuture appointees, (1) to meet all payment obligations for the cost of nursing home care from the Applicant's assets and/or from insurance coverage; (2) to cooperate in obtaining Medicaid coverage, if needed; and (3)to manage the Applicant's assets responsibility so that the facility is not in a position where it is denied payment for the cost of care from the applicant's funds and from Medicaid.

Initials:_____

**Please fill in as completely as possible**

Date of Birth:_____ Place of Birth:_____

Sex: ☐ Male ☐ Female Race:_____ US Citizen: ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Spouse's Name:_____

Veteran: ☐ Yes ☐ No Spouse of Veteran: ☐ Yes ☐ No Branch:_____

Occupation (prior to retirement):_____

Religon:_____

Funeral Home:_____

Prearranged: ☐ Yes ☐ No

## Financial Information

Income–

Social Security: $_____

SSI: $_____

Veteran's Benefits: $_____ VA Claim#:_____

Pensions: $_____ Source:_____

Other: $_____ Source:_____

## Assets

Savings:_____

Certificates of Deposit:_____

Financial Institution & Account Numbers:_____

Stocks:$_____ Bonds:$_____

Life Insurance/Annuity:$_____

Company Name & Address:_____

Rental Income:$_____ Location:_____

Does the Resident own a home? ☐ Yes ☐ No Rent an apartment? ☐ Yes ☐ No

Other Property? ☐ Yes ☐ No Location:_____

Has any property or funds been transferred in the last 5 years? ☐ Yes ☐ No

If yes (please explain): _____

_____

_____

Application for the Alice Center

## Responsible Party

Name:_____ POA: ☐ Yes ☐ No

Address:_____

_____

Phone # Home:_____ Work:_____

Relationship:_____

Prior services provided in your home? ☐ Yes ☐ No

If so, type:_____

Prior hospital stay: ☐ Yes ☐ No Dates:_____

Prior Nursing Home Stay: ☐ Yes ☐ No Dates:_____

Does the applicant smoke? ☐ Yes ☐ No

Advanced Directives–

Do Not Resuscitate order? ☐ Yes ☐ No

Health Care Proxy? ☐ Yes ☐ No

Living Will? ☐ Yes ☐ No

MOLST? ☐ Yes ☐ No

# Application for the Alice Center

I hereby represent that the information on this admission application is a true and accurate reflection of the applicant's personal and financial status. In addition, I hereby authorize this facility to verify all accounts and information contained on this application.

Person Completing this application:

_____ _____

Please Print Date

_____

Relationship to Applicant

_____

Signature

*Please fill out completely
*Please provide copy of Power of Attorney
*Please provide copies of any/all insurance cards (front and back)
*Please provide copies of any Advanced Directives:
DNR (Do Not Resuscitate), HCP (Health Care Proxy), LW (Living Will), or MOLST (Medical Orders for Life Sustaining Treatment).

Thank you for your application. A Patient Review Instrument (PRI) is a New York State requirement prior to admission. If you are coming from a hospital, they will provide the PRI. If you are coming from home, your Primary Care Physician can provide an order so that you can contact Franklin County Public Health to come into the home and make a nursing assessment by a certified PRI nurse. If you wish to transfer from another nursing facility, please contact the facility's social services staff.

*It is the policy of this facility to not discriminate and admit and treat all residents without regard to race, creed, color, place of birth, national origin, sex, sexual preference, marital status, disability, sponsorship, or source of payment.*