

Maple Woods Assisted Living & Memory Care
40170 Co Rd 257 | Cohasset, MN 55721 | 218.999.9072 ext. 2
Fax 218.999.9068 | mwoods@paulbunyan.net

Application for Residency

GENERAL INFORMATION

Date _____

Name _____ Phone (_____) _____

Current Address _____

City, State, Zip _____

Date of Birth ____/____/____ Age _____ Social Security Number _____ - _____ - _____

Gender: M F Marital Status: Single Married Widowed Divorced

Race: Caucasian African American Hispanic Native American Asian Other

Disabled: Yes No Present Living Arrangements: House Apartment Alone With Relative

Living Will: Yes No Do Not Resuscitate (DNR) Order: Yes No (if yes, please attach)

Durable Medical Power of Attorney: Yes No (if yes, please attach)

Primary Contact for Application Process

Name _____ Relationship _____

Address _____ City, State, Zip _____

Phone (_____) _____ Work Phone (_____) _____

Email Address _____

Financial Power of Attorney: _____ *Medical POA _____

*Guardianship: Name: _____ Phone: _____

*Conservatorship: Name: _____ Phone: _____

PLEASE ATTACH COPIES OF POA, GUARDIANSHIP, AND/OR CONSERVATORSHIP, IF APPLICABLE

Billing and Mailing Information

Name _____ Relationship _____

Address _____ City, State, Zip _____

Phone (_____) _____ Work Phone (_____) _____

Email Address _____

Payer Information

Private Pay Long Term Care Insurance Waivered Services Approved Veterans Benefits

Insurance Information

Medicare # _____ Medicaid # _____

If on Medicaid, Case Worker _____ Phone (_____) _____

Medicaid Waiver Service Coordinator _____ Phone (_____) _____

Veteran's Administration # (if applicable) _____

Supplemental Health Insurance Carrier _____ Policy # _____

Application for Residency (continued)

Physician Information

Primary Care Physician Name & Clinic _____
Address _____ City, State, Zip _____
Phone (_____) _____ Fax (_____) _____

Other Medical Providers (psychiatrist, Audiologist, Optometrist, Podiatrist, Cardiologist, Urologist, Dentist)

Name Address Phone Date last seen

Name Address Phone Date last seen

Name Address Phone Date last seen

Name Address Phone Date last seen

Funeral Arrangements

Funeral Home _____
Address _____ City, State, Zip _____
Phone (_____) _____ Prepaid funeral Arrangements? Yes No

Emergency Contacts

Please list below, in the order you want us to contact them, the names of individuals you want us to contact in case you experience an emergency while living at Maple Woods. Also, indicate whether we can release confidential medical information to that individual.

1st Contact Name: _____ Relationship _____
Address _____ City, State, Zip _____
Phone (_____) _____ Work Phone (_____) _____
Email address _____

Release Confidential Medical Information to this individual: Yes No

2nd Contact Name: _____ Relationship _____
Address _____ City, State, Zip _____
Phone (_____) _____ Work Phone (_____) _____
Email address _____

Release Confidential Medical Information to this individual: Yes No

3rd Contact Name: _____ Relationship _____
Address _____ City, State, Zip _____
Phone (_____) _____ Work Phone (_____) _____
Email address _____

Release Confidential Medical Information to this individual: Yes No

Application for Residency (continued)

Allergies

Medication allergy	Reaction
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
Other allergies: (Example latex, tape, etc)	Reaction
1. _____	_____
2. _____	_____

Medical History

Medical Conditions/diagnosis (please list primary first)

1. _____	4. _____
2. _____	5. _____
3. _____	6. _____

History of:

Alcohol Abuse: Yes No unknown Drug Abuse: Yes No unknown

Smoking: Yes No Currently smokes: Yes No

If yes how much? _____ if quit how long ago? _____

Communication Barriers:

Vision: Yes No Correction: _____

Hearing: Yes No Correction: _____

Speech: Yes No Comments: _____

Activities of Daily Living

Activity	Independent	Needs Assistance	Equipment	Comment
Bathing				
Dressing				
Grooming				
Toileting				
Transferring				
Walking				
Positioning				
Eating				

Application for Residency (continued)

Assistive Device(s)

walker: (Circle) Front wheeled or 4 wheeled with bench seat wheelchair toilet riser

mechanical lift brace(s) (List): _____ other _____

When was the assistive device purchased? _____

Skin

Problem: _____ Treatment: _____

Problem: _____ Treatment: _____

Problem: _____ Treatment: _____

Digestive

Diet _____ Food allergies _____

Appetite _____ Weight _____

Indigestion Heart Burn Nausea vomiting Constipation Diarrhea

Last BM _____ Nutritional status _____

Dentures: Top partial full Bottom partial full Other _____

Respiratory

Shortness of Breath COPD Current use of: inhalers nebulizers oxygen

History of Bronchitis pneumonia sinus infection Tuberculosis

Urinary

Catheter: Indwelling Suprapubic Condom

Change Schedule/Responsible person _____

Urinary: Frequency Urgency Nocturia incontinence

History of UTI's or problem with kidney, bladder, or prostate _____

Use of incontinent products? Yes No

Where do you purchase the supplies from? _____

Musculoskeletal

Arthritis, describe _____

Joint replacement, Describe _____

Pain: Frequency/Intensity _____

Relieved by _____

Muscular Disorders _____

Application for Residency (continued)

Endocrine

Diabetes Type I Type II Date of onset _____ BGM _____

Controlled by: Diet Oral Med Insulin

Describe assistance needed _____

Other Endocrine _____

Cardiovascular

Vital signs: _____

peripheral Edema; Location: _____

High Blood Pressure low blood pressure History of MI (myocardial infarction)

Coronary artery disease Cerebrovascular accident / Stroke Describe _____

Neurological

Seizure disorder paralysis _____ Neuropathies _____

Other _____

Mental Health Needs/Behavior Interventions

Alert Oriented to: Person Place Time Date

Anxious Forgetful Depressed Wanders Cooperative

Routinely sees a mental health professional Condition/illness Limits

Behavior Socially Acceptable: Yes No Describe _____

Responds to Redirections _____

Social Supports

Satisfied with Quality of Life: Yes No Family Involvement _____

Friends/Neighbors _____

Community Involvement _____

Church membership/involvement _____

Hobbies Recreation _____

Barriers to pursuing Social Activities _____

Application for Residency (continued)

Do you have a senior Linkage Number? Yes No

If Yes, Number: _____

If No, please review the following information, call for your number and enter it above.



Are you thinking about moving to a Registered Housing with Services setting*?

Before you sign a lease or housing contract you need to call the Senior LinkAge Line® for Long Term Care Options Counseling. It can help you find services that meet your needs.

To receive the service, call the Senior LinkAge Line® at 1-800-333-2433. The Senior LinkAge Line® helps people and their families find local resources and make decisions about long-term services and supports.

You do not need to call in the following situations:

1. You are entering into a *lease-only* arrangement in a subsidized housing setting.
2. You had a Long Term Care Consultation and got verification of the consultation (verification code).
3. You are currently receiving or are being evaluated for hospice services from a licensed hospice provider.
4. You developed a financial long-term care plan within 12 months before you sign and lease or contract. The plan needs to include the following:
 - The plan lists an alternate decision maker if you are unable to make your own financial or health care decisions.
 - The plan covers the financing of the rent and service costs for 60 months after the date you move, and does not include public program payments such as Medical Assistance or Group Residential Housing.
5. You moved into the housing setting on an emergency basis.

*Housing with services providers are registered by the Minnesota Department of Health.

When you call, you will talk with an expert. Together, you will:

- Look at your current situation.
- Find services that may be helpful to you.
- Learn about financing options. These resources might help you pay for services you may need.

Take the following **important** steps:

1. Call the Senior LinkAge Line® at 1-800-333-2433. Or, use the Minnesota Relay Service at 711 or 1-800-627-3529 (TDD). Or call 1-877-627-3848 (speech-to-relay service).
2. The Specialist will ask you some basic questions and discuss your options.
3. At the end of the call you will receive a verification number.
4. Write down the number and put it in a safe place.
5. You will receive a copy of the number by mail.

If you decide to move, give your verification number to the housing provider. Do this before you sign a lease or housing contract.

If you decide not to move, keep the number in a safe place should you later need it.

The Senior LinkAge Line® is a statewide service of the Minnesota Board on Aging and is provided locally through six Area Agencies on Aging. The Senior LinkAge Line® is available by phone at 1-800-333-2433, Monday through Friday, 8:00 a.m. to 4:30 p.m.

MBA-2010-ENG

What this means for you:

- Make just one call for help with making decisions about services or finding help.
- Have better information to make choices.
- Get support to consider all of your options.
- Make the right choice at the right time for you.



Application for Residency (continued)
Maple Woods Assisted Living & Memory Care
40170 Co Rd 257 | Cohasset, MN 55721 | 218.999.9072 ext. 2
Fax 218.999.9068 | mwoods@paulbunyan.net

RELEASE OF INFORMATION

Name _____ Admit Date: _____

Date of Birth ____/____/____ Social Security Number _____ - _____ - _____

Personal, financial, and medical information will be kept private without permission of a client or client's responsible person. Sharing of this information with other health care or third party payers such as health insurance providers, medical assistance, Medicare, or other health programs may be necessary to the provision and payment of your care.

Review the following information and initial any or all persons/organizations to whom the above information may be disclosed.

Applicable personal, financial, and medical information may be released to the following persons/organizations only as it relates to the home care services being provided by:

Licensee Name: **Maple Woods Assisted Living & Memory Care**

Address: **33310 State Hwy 6, Deer River MN 56636**

- Other health care providers as necessary for the provision of health care services
- Health insurance provider/HMO
- Medical Assistance
- Medicare
- Other: (identify) _____
- Other: (identify) _____
- I do not want information released to: (identify) _____

Client/Responsible Party Signature

Date