HOPE CREEK
Care Center
NURSING & REHABILITATION
A R.I.CO. CARE CENTER

Skilled Nursing Facility Admission Application

Return to

Hope Creek Care Center
4343 Kennedy Drive
East Moline, IL 61244
309-796-6600
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Please Look at hopeCreekCare.com

INTRODUCTION

We believe that the nursing home experience should be a positive one...one filled with care, compassion and comfort. It is our goal to provide quality care in a homelike setting that allows the resident to be his/her own person with the encouragement to reach their maximum potential.

We are dedicated to the philosophy:
"To help our residents
do as much as they can,
as well as they can,
for as long as they can."

With this philosophy, our belief is to "Add LIFE
to their YEARS, and not just YEARS to their LIFE."

ADMISSIONS

It is our policy to admit those applicants considered by our staff to be medically and socially appropriate for placement here and who are able to make adequate financial arrangements to cover the expenses for care at the facility.

Our admission process requires complete disclosure of the prospective resident's general background information, medical history and condition, and income, assets, and liabilities. We are relying on the accuracy of the information the prospective resident provides to us when we make our admission decision and to help us know how we may need to assist the prospective resident with financial arrangements.

FINANCIAL ARRANGMENTS

All admissions will be required to sign a financial agreement on or before admission, which must be signed by the prospective resident or his/her responsible party. Admission is contingent upon our ability to meet the needs of the prospective applicant, receipt of medical documentation, verification of payor source and availability of an appropriate bed.

A person qualified and able to serve as the resident's "Responsible Party" will be required to sign an agreement to provide payment to Hope Creek from the resident's income and resources. The Responsible Party may be the resident's Power of Attorney and must have knowledge of and access to the resident's financial resources. Although the Responsible Party is not a third party guarantor of payment, and does not incur person liability for payment, he or she does accept a significant legal obligation to Hope Creek Care Center.

The Business Office will bill your primary and secondary insurance companies. They will answer any questions that you may have regarding your insurance coverage. They can also assist you in applying for Medicaid when financial resources begin to run low. Hope Creek Care Center does not apply for Medicaid on the resident's behalf. The resident's POA/Responsible Party is expected to follow through with this process with the assistance of our Business Office or Social Service staff.

HOPE CREEK CARE CENTER
Admission Application

Date_____

Are you applying for: _____Short Term Stay _____Long Term Placement ____ Respite

IDENTIFICATION:

Last Name: _____ Preferred Nickname: _____
First Name: _____ Middle Initial: _____
Address (Street, City, State, Zip): _____
_____ Phone: _____

PERSONAL INFORMATION:

Birth Date: _____ Age: _____ Social Security Number: _____-_____-_____
Sex: _____ Race: _____ Marital Status: _____ Spouse Name: _____
Previous Occupation: _____ Education: _____
Religion/Church (Name, Address, City, Phone): _____
_____
Birthplace: _____
Military Veteran:
Resident: Yes _____ No _____ Branch: _____
Spouse (name): _____ Yes _____ No _____ Branch: _____
Have you ever been convicted of or plead guilty to a sexual offense or felony in a court of law?
Yes_____ No_____

MEDICAL DESIGNATIONS:

Physician: _____ Phone: _____
Optometrist/Ophthalmologist: _____ Phone: _____
Dentist: _____ Phone: _____
Podiatrist: _____ Phone: _____
Others: _____ Phone: _____

PHARMACY:

Once admitted to Hope Creek, residents must use the pharmacy we have a contract with. Residents/Families cannot bring in medications from outside pharmacies. (Some circumstances may be excluded and can be discussed prior to admission.

NOTIFY IN EMERGENCY:

1.) Name: _____ Relationship: _____
Address (Street, City, State, Zip): _____
Phone No.: (H)_____ (W)_____ (C)_____
Email Address: _____
2.) Name: _____ Relationship: _____
Address (Street, City, State, Zip): _____
Phone No.: (H)_____ (W)_____ (C)_____
Email Address: _____
3.) Name: _____ Relationship: _____
Address (Street, City, State, Zip): _____
Phone No.: (H)_____ (W)_____ (C)_____
Email Address: _____

BILLING PARTY: (who we send the billing statement to)

Name: _____ Relationship: _____
Address (Street, City, State, Zip): _____
Phone No.: (H)_____ (W)_____ (C)_____
Email Address: _____

ADVANCED DIRECTIVES:

Please list Power of Attorney (POA) as described in legal document*

POA for Financial: _____ POA for Healthcare: _____

OR POA for Both: _____

If no legally designated Power of Attorney, please list appointed decision makers:

Medical Decision Maker: _____ Financial Decision Maker: _____

***Please provide Hope Creek with a copy of these documents.**

FUNERAL HOME PREFERENCE:

Name: _____

Address: _____

Phone Number: _____

Prepaid Burial? ____Yes ____No Cost: _____

Has applicant ever been in a skilled nursing facility before? _____Yes _____No

If so, where and when? _____

INSURANCE INFORMATION*

Medicare Number: _____ Part A: ___ Effective Date: _____

Part B: ___ Effective Date: _____

Medicare supplement Ins.: _____ Policy No: _____

Address: _____

_____ Phone No: _____

Do you have a Medicare Replacement policy: _____Yes _____No

If yes, Name: _____ Policy No: _____

Address: _____

_____ Phone No: _____

Medicaid ID No. (if applicable): _____ County: _____

Pending: _____ Approved: _____ Approved Date: _____

Have you previously applied for Medicaid? _____Yes _____No

If yes, provide the date and county of the application: Date: _____ County: _____

Long Term Care Ins.: _____ Policy No.: _____

Address: _____

Phone No.: _____

Do you have a Medicare D (prescription drug) Plan? _____Yes _____No Effective Date: _____

Plan Name: _____ Policy No.: _____

Other Insurance: _____

***Please provide Hope Creek with copies of all insurance cards.**

FINANCIAL DISCLOSURE

Except for personal affects, list all assets owned by **you and your spouse**, with the value as of the date of application.

ASSETS			
Owner(s)	**Description of Asset**	**Location/Bank/Company/Address/Etc.**	**Approximate Value**
	Checking		
	Savings – Passbook		
	Certificate(s) of Deposit		
	Stocks, Bonds, Etc.		
	Life Insurance, Cash surrender value		
	Home(s)		
	Land		
	Life Estates		
	Trust Year created		
	Other (describe)		

List all sources of income for you and your spouse, including but not limited to rental payments, CRP income, long term care insurance benefits, Social Security benefits, Retirement, Pension, IRAs, annuities, veteran's benefits, and employment income.

INCOME		
Description of Income	**Date or Frequency of Payment (i.e. monthly, annually, etc)**	**Amount of Income**
Social Security (self)		
Social Security (spouse)		
Pension (self)		
Pension (spouse)		
Other: (Please list)		

As a resident admitted to Hope Creek Care Center and receiving Illinois Public Aid (Medicaid) or applying for Illinois Public Aid (Medicaid), you are required to pay **all income** less $30.00, which is known as personal care allowance, toward your care. These guidelines are set and required by the State of Illinois. Your income includes: Social Security Benefits, Veterans Benefits, Pensions, Railroad Retirement, Rental income, and Disability insurance, etc.

If the resident is married, the spouse at home will fall under the "Spousal Impoverishment" standards. If the married couple's combined monthly income total is over $2,739, the dollar amount above $2,739 will be due to Hope Creek Care Center. The spouse at home will be able to keep all of the monies below the dollar amount listed here. That resident living at Hope Creek will be able to keep $30.00 per month.

It is your responsibility to provide the payments as soon as the income is received that month. We must receive the payments no later than the tenth of the month. We will make any necessary adjustments regarding the above when we have received final verification from the assigned case worker with the State of Illinois. In the event your Illinois Public Aid application is denied, the amount will be applied toward your private pay balance and you must contact our business office.

I, the undersigned prospective resident/representative, certify to Hope Creek Care Center that all pages of this admission application have been carefully read and understood. All information, including my financial disclosure, is true, accurate, and complete.

Signature: _____ Date: _____
(Resident/Legal Agent/Responsible Party)

HOPE CREEK
Care Center
NURSING & REHABILITATION

2016 PRIVATE PAY DAILY RATES
Updated 7/15/16

$194/day, 2 beds in semi-private room
(approx. $5,820/mo)
$214/day, private room
(approx. $6,420/mo)

MEMORY CARE/SECURED UNIT
$219/day, 2 beds in semi-private room
(approx. $6,570/mo)
$233/day, private room
(approx. $7,170/mo)

Our daily rate includes:
Nursing care-including medical monitoring and treatments
Personal care-including dressing, bathing, and toilet assistance
Medication administration/monitoring
Meals and snacks
Nutritional counseling and therapeutic diets supervised by Registered Dietitians
Social service and counseling for residents and families
Comprehensive social, emotional and recreational programs
Housekeeping and linen service

Items not covered by daily rate:
Pharmaceutical charges/medications*
Diagnostic services-x-ray and laboratory needs*
Items and services ordered by the resident's physician*
Physician visits *
Skilled rehabilitation therapy*
Isolation precautions*
Adult undergarment protection pads
Personal phone
Cable television
Sundries
Hair care at the beauty/barber shop
Laundry service*
Transportation service*

* Medicare pays for these items if you are here with short-term restorative skilled therapy immediately following a three-midnight inpatient hospital stay.