AND CARE CENTER
587 North Deer Isle Rd., Deer Isle, Maine 04627

Application For Admission

Thank you for considering the Island Nursing Home and Care Center, in order for us to best serve you please fill out the following information and return it to the receptionist or mail to:

Attention: Admissions
Island Nursing Home and Care Center
587 N. Deer Isle Road
Deer Isle, Maine 04627

Applicant Identification

Name of Applicant: _____

Applicant's Date of Birth: _____

Applicant's Social Security Number: _____

Will this be your first stay at INH? YES NO

If No, please indicate date of last discharge: _____

Projected Admission Date: _____

Contact Information

Applicant's Current Address: _____

_____

_____

Applicant's Current Phone Number: _____

Applicant's Email: _____

What Level of Care are you hoping to be admitted to? RESIDENTIAL NURSING

Is Someone Helping You Complete this form? YES NO

Name of Person Helping: _____

Relationship: _____

Current Address: _____

_____

_____

Current Phone Number: _____

Email: _____

Is the above listed person your Designated Power of Attorney for Healthcare or Your Guardian? YES NO

Has a Designated Power of Attorney for Health Care been identified? YES NO

Name: _____

Relationship: _____

Current Address: _____

_____

_____

Current Phone Number: _____

Email: _____

Who Should We Contact with Follow Up Questions?

____APPLICANT

____PERSON HELPING

____ DESIGNATED POWER OF ATTORNEY FOR HEALTHCARE

Please include with your application any paperwork naming your Healthcare Power of Attorney.

Current Living Situation

_____Private Home/Apartment (Please indicate level of services needed (circle one)): NF RF

_____ With a Family Member or Receiving In-Home Services

_____Assisted Housing (Please Name Facility): _____

_____Nursing Facility (Please Name Facility):_____

____ Hospital (Please indicate date of admission to hospital): _____

Current Medical Provider Information

Primary Physician: _____

Address: _____

Telephone: _____

Fax: _____

Primary Dentist: _____

Address: _____

Telephone: _____

Fax: _____

DHHS Case Worker/

Therapeutic Clinical Counselor _____

Address: _____

Telephone: _____

Fax: _____

Please fill out the following release of information form. INH will fax this form to your primary physician. Your physician will release ONLY the information listed on the form, not your entire medical record.

Release of Information

I, _____, release the following medical information to Island Nursing Home and Care Center. Please fax the information requested to Amy Van Dorn, LCSW at 207-348-6506.

My Primary Care Physician is: _____

Applicant's Signature: _____

Date: _____

Applicant's Date of Birth: _____

Information Requested

Please Indicate if the Applicant has a History of the Following:

Cognitive Impairment (describe severity and type): _____

_____

Psychosocial Issues (describe severity and type): _____

_____

Cancer (describe severity and type): _____

_____

Depression/Anxiety (describe severity and type): _____

_____

Vascular Issues (describe severity and type): _____

_____

Visual/Hearing Impairment (describe severity and type): _____

_____

Bowel/Bladder Incontinence (describe severity and type): _____

_____

Please include with this information a complete list of current diagnoses and current medications, a list of allergies and the reactions to the allergen, and a copy of the most recent History and Physical.

Financial Information

Payment Source

Will you be **Privately Paying** for your stay? YES NO

If you are Private Pay, How long do you expect to remain Private Pay?

__Less than 6 months

__More than 6 months, but less than 12 months

__More than 12 months

Have you applied for **MAINECARE**? YES NO

Medicaid (MAINECARE) # _____

If no number, what date did you apply? _____

Medicare # _____

Do you receive **SSI/Disability** payments? YES NO

Do you have **Other Insurance** that will be paying for your stay? YES NO

Name of Insurance Company: _____

Policy # _____

Group # _____

Your Finances

Who should we contact in order to talk about your finances? _____

Have you completed paperwork to identify a Financial Power of Attorney? YES NO

Name: _____

Relationship: _____

Address: _____

Phone Number: _____

Email: _____

Please include with your application any paperwork indicating Financial Power of Attorney, and fill out the included release authorization for DHHS.

Department of Health and Human Services
Maine People Living Safe, Healthy and Productive Lives

Paul R. LePage, Governor Mary C. Mayhew, Commissioner

Authorization to Release Information

We are committed to the privacy of your health information. Please read this form carefully.

☑ Office of MaineCare Services	☐ Substance Abuse and Mental Health Services
☑ Office for Family Independence including Medical Review Team	☐ Office of Child and Family Services
☐ Maine Centers for Disease Control and Prevention	☑ Office of Aging and Disability Services
☐ Dorothea Dix Psychiatric Center	☐ Office of Administrative Hearings
☐ Riverview Psychiatric Center	☐ Other:

Individual's Name:	Individual's Date of Birth: Individual's Social Security Number:

Individual's Address:

Street Town/City State Zip Code

Records to be released, including written, electronic and verbal communication:

☑ All Healthcare, including treatment, services, supplies and medicines

☑ Claims Information ☑ Billing, payment, income, banking, tax, asset, and/or other information regarding eligibility for DHHS program benefits such as MaineCare

☐ Other: _____

☐ Limit to the following date(s) or type(s) of information:
(e.g. "lab test dated June 2, 2013" or "hospital records from 1/1/14 - 1/15/14")

I authorize the DHHS office(s) checked above to: ☑ Release my information to: ☑ Obtain my information from:

Name: Island Nursing Home Rep. Heidi Gilken

Address: 587 N Deer Isle Rd (Street) Deer Isle (Town/City) ME (State) 04627 (Zip Code)

Fax No., where applicable: 207-348-5242 Phone No. to verify Receipt of Fax 207-348-6513

If requesting that electronic information be transmitted by email, please clearly print the email address below:

hgillen@islandnursinghome.org

☑ I understand that DHHS systems may not be able to send my information securely through email. I understand that email and the internet have risks that DHHS cannot control and that the information possibly could be read by a third party. I accept those risks and still request that DHHS send my information by email. Initials _____

Please allow the office(s) named above to disclose my information for the following purpose(s):

☐ For a legal matter, including an administrative hearing ☑ To see if I qualify for insurance coverage or benefits
☑ For coordination of my care ☐ A Personal Request ☐ Other (note here):

By initialing below, I agree to disclose the following types of records:

_____ **Mental health treatment provider or program**

_____ **Substance/alcohol/drug Abuse treatment provider or program**

_____ **HIV infection status or test results:** Maine law requires us to tell you that releasing this information may have implications. Positive implications may include giving you more complete care, and negative implications may include discrimination if the data is misused. DHHS will protect your HIV data, and all your records, as the law requires.

I (individual/personal representative of individual) permit DHHS to release and/or obtain my records as written on Page 1 of this form. I understand and agree to the following:

- This form will expire one year from the date I sign below, unless I revoke (take back) my permission sooner by completing, signing and sending in the Revocation Form found on the DHHS website at http://www.maine.gov/dhhs/privacy/index.shtml. I may call DHHS at 207-287-3707 and ask for the office where I receive services if I need help revoking this form.
- I understand that taking back my permission to release my information does not apply to the information that was already shared after I signed this form.
- If I take back my permission to release my information, or if I refuse to release some or all of my healthcare or insurance information, that may result in improper diagnosis or treatment, denial of insurance coverage or a claim for health benefits, or other adverse consequences.
- This form permits the people or offices listed on Page 1 to speak to each other for the purpose(s) on this form.
- If I am disclosing healthcare information, I agree that records of other providers (such as doctors, hospitals, and counselors) in my file are included in this release.
- Unless I am applying for benefits, DHHS will not condition my treatment, payment for services, or benefits on whether I sign this form.
- I have the right to make a written request to review my records. If I wish to receive a copy of my healthcare or billing information, a fee may be charged as permitted by law.
- If I want to review my mental health program or provider records before they are released, I must check **THIS BOX.** ☐ I understand that the review will be supervised.
- DHHS offices will keep my information confidential as required by law. If I give my permission to share my records with people who are not required by law to keep them private, they may no longer be protected by federal confidentiality laws.
- If alcohol or drug treatment or program records are included in this release, federal law requires the person sharing those records to include a notice saying that such information may not be re-released or shared without my written permission, unless required or permitted by law.
- I am signing this form voluntarily, and I have the right to a signed copy of this form if I request one.

Date: _____ Signature_____

Personal Representative's authority to sign: _____