MARQUETTE COUNTY MEDICAL CARE FACILITY

200 Saginaw Street
Ishpeming, MI 49849
(906) 485-1061
Fax (906) 485-4080

Thank you for choosing Marquette County Medical Care Facility for the potential placement of yourself or a loved one. We understand that this is a time of change and would like to help.

We would like to explain the process of admission to a long-term facility. The attached enclosures serve two purposes. One purpose is to inform you of the necessary paperwork, which must be provided by you or your doctor. The medical information provided by your doctor updates MCMCF on the past and present health status, current medications and current lab values and x-rays. The medical information needs to be completed and returned prior to the actual admission date. Mandatory information that must be provided by you or the family include a copy of Medicare, Medicaid, Social Security and supplemental insurance cards. We also need a copy of power of attorney or guardianship papers. Medications are provided by a pharmacy contracted by MCMCF. If the potential resident is being admitted from home we would also like you to bring the bottles of medications here for review. This provides the nursing staff with valuable information regarding what the individual has been receiving. These medications will be returned to you.

The second enclosure, titled pre-admission application, requests more comprehensive information of a personal nature. We encourage you to complete the document for continuity of care. It provides important insight into life events, which have occurred. It enables the staff to anticipate needs and promote the highest quality of life attainable. In addition, these questions will be asked during the admission process. If we can obtain this information prior to arrival, the actual admitting process/paperwork will proceed faster for you.

To summarize, the information we have requested assists us to better understand you or your loved one. We take pride in promoting the highest quality of life attainable for the resident's entrusted in our care. We understand that this transition period can be a difficult time. We would like to make the adjustment period proceed as smoothly as possible. If you have any questions or need guidance or assistance please call.

Sincerely,

Nicole Barlock
Admissions Coordinator
(906) 485-1061 ext. 7224
(906) 204-1061

Tami Mallett
Social Services Coordinator
(906) 485-1061 ext. 7112
(906) 204-1012

Miranda Cobb
Social Worker
(906) 485-1061 ext. 7170
(906) 204-1070

INFORMATION NEEDED FOR POTENTIAL ADMISSION TO MCMCF

A history and physical from your doctor (the history and physical must be dated within five days of arrival to the facility. We will contact your physical for an update if the time frame is exceeded).

A chest x-ray (taken less than 90 days form the date of admission)

Lab work: Electrolytes, BUN, creatinine, glucose and CBC.

Mental health screening forms DCH-3877 and DCH-3878 – **MANDATORY**

A list of all the current medications and dosages, both prescriptions, over the counter medications and herb/vitamins. – **MANDATORY**

MCMCF maintains a no-smoking policy. Please discuss a smoking cessation program with your physician prior to placement.

Identify the source of payment: provide copies of Medicare, Medicaid and supplemental insurance cards. **If this information is not provided, the resident's family will be responsible for payment of monthly charges. We can not bill your insurance without cards.**

A copy of the Social Security Card.

A copy of power of attorney or guardianship papers.

A copy of ADVANCE DIRECTIVES (if available)

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PRE-ADMISSION APPLICATION

Directions: Please fill out this form completely and return. Some questions may not apply to your loved one however to provide optimum care it is imperative that we know as much as possible about this person.

1. GENERAL INFORMATION RELATING TO APPLICANT

Name of Applicant: _____
Last First M.I. Maiden

Address: _____
Street City State Zip Code County

Current Phone _____ Male _____ Female _____
Area Code Number
Social Security Number: _____
Race: _____(optional) Ethnic background _____ (optional)
Marital Status: S M W D If widow/widower, how long? _____
Age _____Date of Birth _____Birthplace _____U.S. Citizen? Yes No
Religious Preference _____ Specific Church _____
Veteran? _____ Wife of Veteran? _____
Branch of Military Service _____
Where is the Applicant now? _____
Is applicant receiving any home health services? Yes/No
Please List _____
Funeral Home _____
Please circle one: Placement ASAP/Placement in the Future

2. WHO IS MAKING THIS REFERRAL?

Name _____Home/Work/Cell_____
Address _____
_____
Relationship to Applicant _____
Does this person have a legal guardian or Power of Attorney? Y/N
Name _____
Address _____
Telephone (Home) _____(Work) _____

Has this person been in a hospital or nursing home within the last 60 days? Y/N
If so, where? _____ Date of Admission to hospital or nursing home _____
Reason for Admission_____

3. FINANCIAL/LEGAL INFORMATION

What is the anticipated source of payment? _____
Medicare # _____Medicaid # _____Private Pay_____

List all current health insurance and include all numbers as well as COPIES of all Cards.
Name of Company _____
Address _____
Policy Holder _____
Numbers _____

Name of Company _____
Address _____
Policy Holder _____
Numbers _____

Has applicant currently have Medicaid? Y/N
_____
If application has been made, where was it filed? _____
County _____
If known, please indicate name of Social Worker _____
Do you anticipate applying for Medicaid? Y/N
If yes, when_____

Amount of: Social Security: _____
Veteran's Pension: _____
Pension: _____
Other Income: _____

Bank Account: Balances or Value

Savings: _____
Checking: _____
Stocks: _____
Bonds: _____
Certificates of Deposit: _____

Insurance Policies: Name of Company: _____
Cash Value: _____

Property deeded in applicant's name: _____
_____

Estimated Value of Property: _____
Burial Trust: No _____ Yes _____
Revocable or non-revokable: _____
Pay source and/or financial arrangements will be discussed with the bookkeeper prior to admission.

I will inform the facility of the date and time of the appointment for application. I understand that failure to complete a Medicaid application or denial from Medicaid shall make the applicant financially responsible.

To the best of my knowledge, the above information is complete and accurate.

_____ _____

Signature Date

4. MEDICAL/NURSING INFORMATION

List the applicant's primary physician_____
When was the person's last visit to an MD? _____
When was the person's last chest x-ray? _____
List the applicant's dentist_____
Date of last exam _____Does this person wear dentures? Yes/No
Who is the applicant's eye doctor? _____
Date of last exam _____Does this person wear eyeglasses? _____
Does this person wear hearing aides? Yes/No How Many _____
List any medical problems _____
_____
List any emotional or psychiatric problems _____
_____
Has applicant ever been diagnosed with tuberculosis Yes/No
Does this person have any open areas on the skin? Yes/No
List any medication or food allergies. BE SPECIFIC _____
_____
List ALL medications and Dosages.
_____
_____
_____
_____
_____
_____

Is he/she on a special diet? What kind? _____
Can he/she feed themselves? Yes/No
Can applicant use toilet by themselves? Yes/No If not please explain _____
Can he/she walk? _____Does he/she need assistance? _____
Is applicant able to get in/out of bed independently? Yes/No If No please explain
_____
Please circle which equipment applicant uses walker, wheelchair, cane

5. SOCIAL SERVICES/ACTIVITIES

What was the applicant's former occupation? _____
List any important life events of this person (both good & bad) _____
_____

List any hobbies or activities he/she might enjoy? These may include anything from visiting with others to reading or watching TV _____
_____
List anything specific you think would be important for us to know. This can include "likes and "dislikes" _____
_____
Do you see this placement as permanent or temporary? Explain _____
_____

6. BACKGROUND INFORMATION

Mothers name _____
Fathers name _____
City, State of birth _____

Choose one: Laundry completed by Family or Facility

PHYSICIANS AVAILABLE (Please circle one):

Dr. Catherine Kroll, Gwinn, 346-9275 (Transport to Marquette General)

Dr. Riley Torreano, Ishpeming, 485-2687 (Transport to Bell Memorial)

Dr. Amelia Sramek, Ishpeming, 485-2687 (Transport to Bell Memorial)

Dr. Wayne Carlson, Ishpeming – 485-1061 (Transport to Bell Memorial)

Tuberculosis (TB) Test History

Resident name: _____ Date: _____

Have you (this resident) ever had a TB (PPD) skin test?
____ Yes
If yes, date of last test, if known _____
Result of test: negative or positive

____ No, have never had test to my knowledge

Have you (this resident) ever been diagnosed with TB? _____ Yes _____ No

Have you (this resident) ever had contact with a person who had TB? _____ Yes _____ No

Have you (this resident) ever been told not to receive the TB test? _____ Yes _____ No