APPLICATION FOR ADMISSION

Houghton County Medical Care Facility
1100 W. Quincy Street • Hancock, Michigan 49930
(906) 482-5050

IMPORTANT — PLEASE COMPLETE IN FULL

1. Name _____ Age _____ Sex _____
   (Last) (First) (Middle)
2. Date of Birth _____ Place of Birth _____ Maiden Name _____
3. Present Location of Applicant _____ Phone _____
4. Present Home Address _____
5. Previous Home Address _____
6. Current Marital Status: (circle one) Married Single Widowed Divorced Separated

   Name of Spouse _____ Address _____ Phone _____
7. Nationality _____ Foreign Language Spoken _____
8. Religion _____ Parish _____ Clergyman _____
9. Veteran _____ Service Branch _____ Veteran Claim No. _____

10. Physician's Name _____ Dentist's Name _____
11. List in the spaces provided, the ***exact*** dates and names of any hospitals or facilities (including nursing homes) you have stayed at in the past 120 days (4 months). Also include any periods you may have been at home.

Facility Name	Dates From	Thru
_____	_____	
_____	_____	
_____	_____	
_____	_____	

12. Medicare No. _____ Effective Date _____
13. Medicaid Recipient No _____ (through Dept. of Human Services)
14. Social Security No. _____
15. Do you have any health insurance: ☐ Yes ☐ No (Do not include life insurance.)

    Blue Cross & Blue Shield — Other _____ (Name of Company)

    Group No. _____ Address _____

    Contract No. _____

    Service Code _____ Policy or Contract No. _____

    _____ Telephone No. _____

*If more room is needed, please continue on back of application.

16. Are you a U.S. Citizen? ☐ Yes ☐ No How long in U.S.? _____

17. In what county are you a resident? _____ How long? _____

18. Are you a registered voter? ☐ Yes ☐ No Township where registered _____

19. Funeral Home desired _____ Arrangements made ☐ Yes ☐ No

20. Do you have an Irrevocable Funeral Agreement? ☐ Yes ☐ No

21. Number of Children of applicant: _____

Name	Age	Address	Telephone	Business Telephone

22. Other Relatives or Interested Friends:

Name	Age	Address	Telephone	Business Telephone

23. Method of Payment: (circle any appropriate source) As of (Date)
Medicare Medicaid Private Pay Private Insurance

24. Are you receiving benefits from: (circle any appropriate source)
Social Security Supplemental Security income Pension Other (list) _____

25. Important information concerning Resident Rights:
Does applicant have any of the following:

a. Legal Guardian (court appointed ☐ Yes ☐ No) If so, whom?

Name	Address	Telephone	Date of Appointment

b. Durable Power of Attorney ☐ Yes ☐ No If so whom?

Name	Address	Telephone	Date of Appointment

c. Patient Advocate Designation/Durable Power of Attorney for Healthcare

Name	Address	Telephone	Date of Appointment

26. Does applicant have an appointed person responsible for financial arrangements?
Are you officially appointed to this capacity? ☐ Yes ☐ No

Name	Address	Telephone	Date of Appointment

27. Reason for nursing home admission _____

28. Does applicant accept idea of placement? _____

29. The Houghton County Medical Care Facility building and property is smoke free. Does the applicant (resident) currently smoke? ☐ Yes ☐ No

    Does the applicant (resident) understand that they cannot smoke in the Facility or on the Facility property? ☐ Yes ☐ No

30. Please indicate if you are interested in our memory care unit (Woodland Haven) for Alzheimer's disease and other related dementias ☐ Yes ☐ No

31. Person(s) to notify in case of emergency:

    1. _____
    Name Address Telephone

    2. _____
    Name Address Telephone

32. Applicant's signature only: _____
    (or officially appointed representative per item 25 above)

33. Relationship to Applicant _____

34. Person who helped complete this application _____

35. Date of application _____

36. Are you seeking possible admission ☐ immediately, ☐ within 3 months, ☐ within 6 months, ☐ within 12 months ☐ unknown at this time.

Upon admission to the facility we will ask you to provide us with a copy of the following:

- Social Security card
- Medicaid card
- Medicare card
- Medicare Part D provider card
- Any other insurance cards
- Guardianship/DPOA Forms (if applicable)