Sentara MeadowView Terrace

Application for Admission

P.O. Box 1600
184 Buffalo Road
Clarksville, Virginia 23927

Admissions Coordinator
Phone: (434) 374-4141
Fax: (434) 374-4491

SENTARA®

Authorization Agreement For Responsible Person For Potential Resident

I, _____ give authorization to _____
Potential Resident Responsible Person

To sign all admission paperwork to Sentara MeadowView Terrace. He/She has my permission to make all decisions for my care and treatment for nursing home placement. Any information pertaining to my health may be released to her/him at any time.

Signature: _____

Date: _____

Health information may also be released to the following:

_____

_____

_____

Sentara MeadowView Terrace does not discriminate against any person on the basis of race, color, national origin, disability, or age in admission, treatment, or participation in its programs, services and activities, or in employment.

For further information about this policy, contact:

Betty DeOrnellas at 1-434-374-3003

Dear Applicant:

Thank you for your interest in Sentara MeadowView Terrace. Please complete the attached application and return it with the following information to the Admissions Coordinator at Sentara MeadowView Terrace as soon as possible.

1. Chest X-Ray results which were obtained within thirty (30) days prior to admission
2. **One step purified protein derivative (PPD) test results.**
3. Current physical examination within the past thirty days and a history of applicant's medical condition. If coming from home a history & physical is required from your attending physician.
4. Copies of all insurance cards, Advance Directives, Power of Attorneys and Living Will.
5. If competent to make this decision the potential resident must complete the authorization on the previous page authorizing responsible person who can make decisions for care and treatment for nursing home placement.

If the applicant is currently a Medicaid recipient or seeking Medicaid assistance, Sentara MeadowView Terrace will verify Medicaid eligibility.

A preadmission screening (Virginia Uniform Assessment Instrument) is required for all individuals who, at the time of application for admission to a certified nursing facility are eligible for Medicaid coverage or will become eligible within six months following admission.

North Carolina residents are required to submit an FL2.

If you have any questions concerning the application or other required information for admission, please contact Sentara MeadowView Terrace Admissions Department at (434) 374-3002.

Sincerely,

Janice R. Colgate
Admissions Coordinator

Application for Admission

Date of Application:

Application For: **Preferred Physician:**			**SSN:** Current Physician:
Address: **Telephone Number:** **Spouse Name:**	Sex: ☐ M ☐ F	Date of Birth	Birthplace:
	Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated	Age:	Primary Language:
		Education:	Nationality:
		Religion:	Occupation:
		Military Experience: ☐ Yes ☐ No VA Benefits: ☐ Yes ☐ No	

Admission Desired: Date:_____ ☐ Temporary ☐ Indefinite

Skilled Care Admission: ☐ 3 Consecutive midnights in hospital or ☐ Transferred from another skilled facility.

Date of Hospital Stay:

_____,_____,_____

Is Applicant aware that Nursing Home Placement is being made? ☐ Yes ☐ No

Hospital Stay during past six (6) months? ☐ Yes ☐ No Last Discharged Date

If yes, name and address of hospital: ☐ Sentara Halifax Regional Hospital ☐ Other: _____
2204 Wilborn Ave. _____
South Boston, Va. 24592 _____

Has Applicant been in a Nursing Facility Before? ☐ Yes ☐ No ☐ NF Level ☐ Skilled Care
☐ Hospice Care ☐ Assisted Living

Name of Facility:

Address:

Admission Date:

Reason for discharged from other facility:

Please check below if the Applicant has the following: (Please provide copies of documentation)
☐ Power of Attorney. ☐ Guardian ☐ Representative Payee
Name: _____ Telephone No: _____
Address: _____
City: _____State: _____ ZIP: _____

Please provide copies of all Insurance Cards.

Type of Pay: ☐ Private ☐ Medicare ☐ Long Term Care Insurance Med. Adv. _____
☐ Medicaid No: (12 digits) _____ Effective: _____
☐ Pending Medicaid County: _____ Eligibility Worker: _____

Medicare No: _____ ☐ Medicare Part D Effective Date: _____
☐ Medicare Part A Effective Date: _____ ☐ Medicare Part B Effective Date: _____

☐ Other Insurance: ☐
Name of Company: Subscriber No: Group:

UAI Screening Completed: ☐ Yes Date: _____
Nursing Home Screening: ☐ No If No, scheduled for: _____

Financial Information: To determine if a preadmission screening is required please answer the following questions:

Does the applicant have funds available to cover at least six months of care? ($45,000) ☐ Yes ☐ No
Has the applicant transferred ownership of any property and/or resources in the past five years? ☐ Y ☐ N
If yes, please provide date of transfer: _____
Does the applicant have any ownership in real property? ☐ Yes ☐ No
If yes, please provide type, location and value of real estate owned: Please provide a copy of the last tax assessment on property.
Location of property: _____
Value of real estate owned: _____
Does resident have a life insurance policy? ☐ Yes ☐ No Cash Value: _____
Does resident have a burial fund? ☐ Yes ☐ No

Attach copies of statements for accounts with funds available to applicant totaling $45,000. Balances in joint accounts, as defined by Social Services, are divided equally between owners so funds considered available to the applicant are limited to his or her share of the account.

Source of monthly income: (check all that apply)

☐ Social Security (Amount: _____)
☐ Veterans Pension Amount:_____)
☐ Civil Service Annuity: (Amount of check is: _____)
☐ Retirement (Amount: _____)
☐ Supplement Income (Upon admission to a nursing home residents are not allowed to receive SSI benefits unless it is determined by Social Services.) This must be returned to Social Security immediately after admission.
☐ Other: (Amount: _____)

All of the information above is true and correct to the best of my knowledge. No requested information has been withheld or misrepresented. Permission is granted to verify and retain all information necessary to appraise the application. Verification may include confirmation by financial institutions.
I understand this is not a guarantee of admission.

Signature of Applicant or Responsible Party:

_____ Date: _____

Responsible Party Information:

Mailing Address: _____

_____

Telephone Number: Home: _____ Work: _____ Cell: _____

Relationship: _____

This application was completed by: _____ Date: _____

Please turn this application into the Admission Department at Meadowview Terrace.
Attention: Janice Colgate Admission Coordinator

Vision

Learning enables individual and
organizational success

Mission

To help Sentara “Improve Health Everyday“ we:
Facilitate organization-wide change through innovative learning strategies

Our Commitment to Sentara…….

Provide exceptional service – delight them
Be accurate and thorough
Be trustworthy
Role model leadership and teamwork to inspire success
Think big. Start small. Grow quickly.