



DuPage Convalescent Center, 400 N. County Farm Road, Wheaton, IL 60187 (630) 665-6400

This application must be submitted in its entirety to be considered for admission, please contact the Admission Office at (630) 784-4315 with questions, comments or concerns.

Long Term Care
Application

Residency Requirement: Any person seeking admission to Long Term Care must be a DuPage County resident for 1 year prior to admission. Prior residency may be taken into consideration.

Application Process: Please return or FAX (630-784-4319) the following documentation with your application. Clinical and Financial Approvals are required prior to admission.

DPCC APPLICATION CHECKLIST	
✓	
	Pre-Admission Medical Form - if coming from home Medical Information (H&P, Labs, RN notes, Psych notes, MAR) – if coming from a facility
	Completed application including Social History, Medical Information, Activities of Daily Living, Temperament, Discharge Plans and Physician to Follow information
	Smoking Policy Acknowledgement and Agreement
	Financial Affidavit , signed and notarized with supporting documentation
	Advance Directives – copies only please
	Power of Attorney – Health Care
	Power of Attorney – Property
	Guardianship papers (if applicable)
	Living Will
	Surrogate for Health Care
	Medical Coverage Cards – copies of front and back
	Medicare Card
	Medicaid Card
	Social Security Card
	Insurance Card
	Proof of Citizenship – usually Birth Certificate or Passport – complete list available
	Driver’s License or State Identification Card – copy
	Pre-Admission Screening/Determination of Need (PAS/DON) *

*A Preadmission Screening/Determination of Need (PAS/DON) from one of the following agencies:

- DuPage County Department of Senior Services for applicants over age 60 (630) 407-6500.
- Department of Rehabilitation Services (DORS) for applicants with illness or injury occurring after age 21 and before age 60 (630) 495-0500.
- PACT Inc., for applicants with illness or injury occurring before age 21 (630) 960-9700. Please note that these screenings are only valid for 90 days.

A **Financial Review Meeting** to discuss the Financial Affidavit will be scheduled after medical review is complete and applicant is clinically approved. This meeting must be prior to admission and may be scheduled at (630) 784-4201. Please bring copies of all information supplied at time of application submission and any new supporting documentation such as, change of income or insurance, sale of home, etc.



Application For Admission

The resident is our primary concern. In order to provide the best care possible, and to meet state regulations, we request that you answer these questions. Please be as thorough as possible.

For Office Use Only:

Adm. Date: _____
 From: _____
 Physician: _____
 MR#: _____ L.O.C.: _____
 Status: _____ Room: _____
 Entered: _____
 PAS Completed By: _____ Date: _____

Name (Last)	(First)	(Middle Name)	Sex	Birthdate	Birthplace
Previous Name(s):			Date(s) Changed:		
Current Street Address		City	State	Zip	How long at this address? Telephone Number
Previous Address		City	State	Zip	How long at this address? Convicted of a felony: <input type="checkbox"/> Yes <input type="checkbox"/> No
Citizen of	Race	Marital Status	Previous Occupation & Employer	Driver's License No., State & Expiration Date	
Social Security Number	Maiden Name	Spouse's (Maiden) Name	Father's Name	Mother's (Maiden) Name	
Medicare Number	Hospital Effective Date	Medical Effective Date	IDPA/Medicaid Number		
Medicare Supplemental Insurance Company		Group #	I.D. #		
Primary Insurance Company or H.M.O. (within last 60 Days)		Group #	I.D.#	Veteran Yes/No	
Personal Physician	Telephone Number	Dentist	Telephone Number		
Religious Preference	Name of Church/Synagog		Location		
Indicate if the following Advance Directives have been completed (submit copies with completed application): Living Will _____ Power of Attorney for Healthcare _____ Power of Attorney for Estate/Property _____ Does applicant desire a "Do Not Resuscitate" (D.N.R.) order? _____					
Funeral Director	Telephone Number	Allergies:			

Whom to Notify	Relationship	Address	Telephone
#1			Home: Business: Cell:
#2			Home: Business: Cell:
#3			Home: Business: Cell:

In accordance with Illinois State law, the DuPage County Convalescent Center will be running a criminal background check on all persons prior to admission to this facility. By completion and submission of this application, you are giving consent for a criminal background check to be conducted electronically.

SOCIAL HISTORY

Applicant's Name: _____

Family: Where was applicant raised? _____ If foreign born, age came to U.S. _____
 Number of living brothers _____ Deceased brothers _____ Cause of death _____
 Number of living sisters _____ Deceased sisters _____ Cause of death _____
 Number of living sons _____ Deceased sons _____ Cause of death _____
 Number of living daughters _____ Deceased daughters _____ Cause of death _____
 Names and ages of children under age 21 _____
 Name or "Nickname" applicant responds to _____
 Primary caregiver or support person _____ Relationship _____
 Address _____ Telephone _____

Marriage: Date married _____ Date widowed _____ Date divorced _____
 Date separated _____ More than one marriage? _____ If yes, how many? _____

Education: Extent of applicant's education _____
 Any special training or courses? _____
 Does the applicant speak and understand English? _____ If not, what language do they speak? _____
 Other foreign languages spoken _____
 Previous employment _____ Company _____

Registered Voter? Yes No **If not, is applicant interested in becoming registered upon admission?** Yes No

MEDICAL INFORMATION

Physical Description: Weight _____ Height _____ Color of Hair _____ Color of Eyes _____
 Right Handed _____ Left Handed _____ General Description _____

Health History:

Current Illness _____

Past Illness _____

Surgeries and Dates _____

Fractures and Dates _____

Fused joints or metal implants _____

Seizures or convulsions _____

Psychiatric or emotional problems _____

Psychiatric hospitalizations (list ALL hospitals and dates) _____

History of alcohol abuse No Yes List treatment (if applicable) _____

History of other substance abuse and treatment _____

History of tuberculosis (or positive test for tuberculosis) No Yes If yes, explain _____

Currently a smoker? _____ Type and frequency _____ Previously a smoker? _____ Stop date _____

Hereditary tendencies in family, i.e. Cancer, Diabetes, Epilepsy, Heart Problems _____

Hospitalizations:

Hospitals _____ Dates _____

_____ Dates _____

_____ Dates _____

Nursing Homes _____ Dates _____

Why did resident leave? _____

_____ Dates _____

Why did resident leave? _____

Has the applicant been funded by Medicare in a Nursing Home? No Yes Dates _____

Has the applicant ever been a resident of DuPage Convalescent Center? No Yes Dates _____

Has the applicant ever received outpatient services at DuPage Convalescent Center? No Yes Dates _____

List prior use of home health care agencies, Meals on Wheels, or other community resources _____

Applicant's Name: _____

In order for our staff to assess the applicant for appropriate placement and to establish a plan of care and rehabilitation goals, the following information is required.

ACTIVITIES OF DAILY LIVING

Does the applicant require assistance with the following activities of daily living? (Check all that apply)

- Dressing Bathing Feeding Transferring to: Chair/Wheelchair Toilet Bed
- Walking Use: Walker Wheelchair *Motorized Wheelchair (Electric Mobility Device)

(*Please note that DuPage Convalescent Center retains the right to evaluate a resident's abilities on an electric mobility device prior to the use of one in this facility. DuPage Convalescent Center will provide a manual wheelchair when appropriate.)

Able to manage own finances? Yes No

List other activities with which applicant requires assistance _____

TEMPERAMENT (check all that apply)

- Sociable Mentally alert Forgetful Verbally aggressive
- Timid Confused Anxious Physically aggressive
- Independent Suspicious Grouchy Strikes out
- Prefers being alone Withdrawn Cries easily Wanders off
- Prefers groups Depressed Chronic complainer

DISCHARGE PLAN/REHABILITATION GOALS

Discharge Plan:

The applicant expects to:

- Return home alone Begin living with family Enter Retirement Center
- Remain at DuPage Convalescent Center Other _____

Rehabilitation Goals:

Indicate the skills that you believe the applicant needs to gain before they could be discharged to their previous residence:

- Speaking Eating Feeding self
- Use bathroom independently Dress self Bathe self
- Walk with walker/cane Walk independently Climb stairs
- Light housekeeping Shop and travel alone Other _____

Physician to Follow at This Facility (Physician and alternate must be credentialed with this facility)

I choose to use the facility Medical Director and his Convalescent Center Physician Associates **OR**

I choose to use a Private Physician

Name of Physician: _____ Name of Alternate Physician: _____

Admission to a Skilled Nursing Facility is a significant change for the individual entering the facility and also for their family. It is generally a more positive experience when the applicant is involved in making the choice. We therefore request that the applicant be informed of plans for admission to the DuPage Convalescent Center as soon as possible.

Reason For Placement:

Briefly describe why you feel placement is needed:

Does the applicant have sufficient personal funds to pay for all charges not covered by Medicare or Insurance? Yes No

Has Medicaid been applied for? No Yes If yes, Date _____ Location: _____

Telephone _____ Date _____

Signature of person completing this application

PREADMISSION MEDICAL EXAMINATION: (TO BE COMPLETED BY THE PHYSICIAN)

RETURN TO
 DuPage Convalescent Center
 400 N. County Farm Road
 Wheaton, IL 60187
 (630) 665-6400
 Fax # (630) 784-4319

Name _____ Age _____
 (last) (first) (middle)

MAJOR DIAGNOSES:

Psychiatric/Psychosocial Problems:
 (dates, placement, treatment mode, medications used)

SURGICAL PROCEDURES AND DATES:

IMPORTANT MEDICAL INFORMATION:

History of infection during hospitalization _____
 _____ MRSA _____

History of communicable disease _____

ALLERGIES:

MEDICATIONS / DOSES / TIMES: (BY STATUTE; EACH MEDICATION MUST BE SUPPORTED BY DIAGNOSIS)

TREATMENTS:

THERAPY:

(physical, occupational, speech, nutritional)

MOST RECENT LABORATORY/X-RAY RESULTS:

Chest X-Ray date _____ result _____
 C.B.C. date _____ result _____
 Mantoux step #1 date _____ result _____
 step #2 date _____ result _____
 Urinalysis date _____ result _____
 Pneumococcal Pneumonia Vaccination: date _____
 Flu Vaccination: date _____
 Culture Data (if completed within the last 30 days):
 Sputum date _____ result _____
 Urine date _____ result _____
 Blood date _____ result _____
 _____ date _____ result _____

FUNCTIONAL LEVEL (Please check all that apply)

I - INDEPENDENT
A - NEEDS ASSISTANCE
U - UNABLE TO PERFORM

I A U

BED ACTIVITY:

Turns
 Sits

PERSONAL HYGIENE:

Face, Hair, Arms
 Trunk & Perineum
 Lower Extremities
 Bladder Program
 Bowel Program

DRESSING:

Upper Extremities
 Trunk
 Lower Extremities
 Appliance, Splint

FEEDING:

TRANSFER:

Sitting
 Standing
 Tub
 Toilet

MOBILITY:

Wheelchair
 Walking
 Stairs

PATIENT USES:

Appliance Colostomy
 Cane Catheter
 Walker Indwelling
 Wheelchair External
 Prosthesis Other _____

BEHAVIOR:

Strikes out Noisy
 Belligerent Alcoholic
 Withdrawn Suspicious
 Verbally aggressive

SAFETY:

May wander off
 Requires Secured Unit

MENTAL STATUS:

Alert Forgetful Confused

COMMUNICATION ABILITY:

Can speak Can write
 Understands: Speaking Writing English
 If no, indicate which language is spoken _____

DIET:

General Special _____
 Gastrostomy Tube Feeding _____

RESPIRATORY:

Oxygen _____ L/min. via _____
 Nebs Trach Suction/Frequency _____
 BIPAP C-PAP Other _____

Date _____ Physician's Signature _____
 Physician's Telephone Number: _____

PAYMENT INFORMATION

- All residents are considered to be Private Pay Status until a Public Aid Application has been submitted to the Department of Health and Family Services and a case number is assigned. All payments are due upon receipt.
- **It is understood by the applicant that anyone not able to provide the necessary funds to pay for their own care at the DuPage Convalescent Center will themselves, or will allow a responsible adult known to the applicant, to apply for medical financial assistance at:**

**Illinois Department of Health and Family Services
146 West Roosevelt Road, Suite 2
Villa Park, IL 60181
Telephone: (630) 530-1120**

- The DuPage Convalescent Center's Admission office can provide general information about the application process for Medicaid/Public Aid and how income is to be applied toward the cost of care at the Center.
- The attached Applicant's Comprehensive Financial Disclosure Affidavit must be fully completed and returned along with the application for consideration of admission to this facility. The signature on the Affidavit must be notarized. Upon clinical review and clinical acceptance to the facility, and a bed has become available, an appointment will be set up for the applicant or their representative to complete a Financial review.

IMPORTANT MEDICARE INFORMATION

If the applicant is to be admitted to a Medicare Certified bed, the length of Medicare certification is NOT guaranteed at the time of admission and will be determined by the Utilization Review Committee and/or medical staff in accordance with Medicare requirements.

Please read the following statements regarding Medicare coverage in a Skilled Nursing Facility. It is most important that the applicant and his/her responsible person fully understand this information.

- Although the applicant has a Medicare card he/she may NOT be medically eligible for Medicare coverage in this facility.
- The medical criteria that may make the applicant eligible for coverage in this facility is established by Medicare and must be followed by the Utilization Review Committee and our medical staff.
- Medicare offers potential coverage for Rehabilitative/Skilled Care as follows: a) from day 1-20 of a Medicare placement, funding coverage is 100%, if eligible, b) from day 21-100 the resident/patient is responsible for a coinsurance amount per day, which is established annually by Medicare, and Medicare covers the rest of the fees.
- **MEDICARE DOES NOT GUARANTEE THAT YOU WILL RECEIVE THE ENTIRE PERIOD OF COVERAGE**
- Medicare may deny coverage of part or all of the time of this placement if review of the medical record determines that Rehabilitative/Skilled Care was not required.
- **THE RESIDENT/PATIENT IS RESPONSIBLE FOR ALL CHARGES NOT COVERED BY MEDICARE OR OTHER INSURANCE CARRIER.**

Signature of Applicant or Person Completing Application

Date

STATE OF ILLINOIS)
) SS
 COUNTY OF DUPAGE)

APPLICANT'S COMPREHENSIVE FINANCIAL DISCLOSURE AFFIDAVIT
(Form must be fully completed for consideration, please us N/A if Not Applicable)

Applicant Name: _____ Telephone: (____) _____

Home Address: _____ Rent Own Live w/Family – No Rent

City, State, Zip: _____ Date of Birth: _____

Driver's License # _____ SSN: _____

Employer name: _____ Telephone: (____) _____

Employer address: _____

Total number of persons in household: _____ Relationship/Ages: _____

Number of dependents: _____ Relationship/Ages: _____

Name and Address of Health Insurance Company:

Primary: _____ Address: _____

Phone: _____ Group #: _____ Policy #: _____

Secondary: _____ Address: _____

Phone: _____ Group #: _____ Policy #: _____

Supplemental: _____ Address: _____

Phone: _____ Group #: _____ Policy #: _____

Long Term Care: _____ Address: _____

Phone: _____ Group #: _____ Policy #: _____

Name of person completing form, if other than applicant: _____

Home Address: _____

Phone Number(s): (Please provide best time to call) _____

HOUSEHOLD INCOME

A. GROSS SALARY OR GROSS INCOME FROM BUSINESS (BEFORE DEDUCTIONS)

	Household Member Name	Source	Monthly Amount
1.	Self: _____	_____	_____
2.	Spouse: _____	_____	_____
A. Sub-total:			_____

B. HOUSEHOLD INCOME FROM OTHER SOURCES

1.	Social Security (Self) _____	_____
	Social Security (Spouse) _____	_____
2.	Pension(s) _____	_____
	_____	_____

- _____
- _____
- 3. Interest, Dividends, Rent, Annuities, Insurance _____
- _____
- _____
- 4. Deferred Compensation or Other After-Tax Investments _____
- _____
- 5. Other Sources of Income _____
- _____
- _____
- 6. Alimony and Child Support _____

B. Sub-total: _____

TOTAL INCOME (Subtotal A+ Subtotal B): _____

C. ADDITIONAL ASSETS	AMOUNT
Checking Acct(s) (Bank): _____	_____
_____	_____
_____	_____
Savings Acct(s) (Bank): _____	_____
_____	_____
_____	_____
Mutual Funds (Company): _____	_____
_____	_____
_____	_____
Stocks/Bonds (total): _____	_____
Trust Accounts (Institution): _____	_____
Real Estate (List Address(s)): _____	_____
_____	_____
_____	_____
Other (Specify): _____	_____
Other (Specify): _____	_____
Other (Specify): _____	_____

C. Sub-total: _____

Applicant Name: _____ *Page 3 of 4.*

D. LIABILITIES

Rent or Mortgage Payments (specify): _____

Real estate taxes, assessments: _____

Utilities (all): _____

Supplemental Insurance Premium: _____

Automobiles (all): _____

Other debts (specify): _____

Other debts (specify): _____

D. Sub-total: _____

E. ATTACHMENTS

List any attached documents to be incorporated by reference in this affidavit:
 (Copies supporting all items listed above are required)

✓	Please provide supporting copies for all information listed above, the following checklist is provided to assist you. Some items are included on the application checklist.
	Check stub(s) or statement(s) showing Direct Deposit of income from an employer
	Social Security Check(s) or statement showing Direct Deposit of benefits
	Pension Check(s) or statement showing Direct Deposit
	Investment Disbursement Statements
	Alimony or Child Support. Other Benefit Program, i.e. SSI, Veterans Benefits
	Checking Account and/or Savings Account Statement(s)
	Mortgage Statement
	Real Estate Tax Bill showing current value of home
	Auto Loan Statement
	Utilities (Electric, phone, water, gas)
	Other Debts, i.e. Credit Card Statement(s)
	Past 2 Years of IRS Tax Returns

Applicant Name: _____ *Page 4 of 4.*

STATE OF ILLINOIS)
) SS
COUNTY OF DU PAGE)

VERIFICATION BY CERTIFICATION

I, _____, hereby swear and affirm, under penalty of perjury pursuant to Section 5/2-109 of the Illinois Code of Civil Procedure, that the statements set forth in this instrument are a true and accurate statement of financial information, for the above listed applicant, including any attachments incorporated herein, as of _____, 20_____.

AFFIANT SIGNATURE

The following portion must only be completed if the Resident's Power of Attorney for Property has completed the Application for Admission on the Applicants behalf.

I, _____, on behalf of the Applicant, have completed this Application and further swear and affirm that as Power of Attorney for Property for the Applicant I have access to the Applicant's personal funds as detailed in the above paragraphs A, B and C hereof.

SUBSCRIBED and SWORN to before me this

____ day of _____, 20_____.

NOTARY PUBLIC