Trinity Center

Application for Admission - Please print or type

Please complete the application in its entirety including the financial statement on the following pages. This application does not constitute any guarantee of admission. The information contained in this application will be held in strict confidence. This application does not constitute any guarantee of admission. However, upon admission, the application becomes a part of the Admission Agreement. Please complete the application in its entirety including the financial statement on the following pages. Information should be only for the person being admitted.

Applicant(s):

Mr. ☐ Mrs. ☐ Miss. ☐ Applicant(s) _____

Current Address _____ City _____ State _____ Zip _____

Phone _____ Cell Phone _____

Date of Birth _____ Birth Place/State _____ Age _____

Marital Status Single ☐ Married ☐ Widowed ☐ Divorced ☐

Social Security # _____ Medicare # _____

Co-Insurances _____ City _____ State _____ Zip _____ Policy # _____

Have you or your spouse ever served in the armed services? You: Yes ☐ No ☐
Spouse: Yes ☐ No ☐

Church Name _____ Pastor Name _____ City _____ State _____ Zip _____

	Name	Address (Street, City, State, Zip)	Phone
Physician			
Dentist			
Pharmacy			
Hospital			

Applicant was refered by _____

Applicant is being admitted from _____ Patient Illness _____

Previous stay in nursing home? Skilled care Yes ☐ No ☐ Date: _____ Intermediate Care Yes ☐ No ☐ Date: _____

Trinity Center

Does applicant have the following? If marked "yes", please provide copies of the documents.

DOCUMENT	Yes	No	Name of POA's, Conservator, Guardian
Living Will*			
*Physician statement enacting POA's			
General Power of Attorney			
Healthcare Power of Attorney			
Financial Power of Attorney			
Conservator			
Guardian			
Pre-paid Burial			

Funeral Home Preference:

Address _____ City _____ State _____ Zip _____ Phone _____

In case of emergency, please notify the following (Please list in order of preference)

Name, Mailing Address, City, State, Zip	Relationship	Phone Number Work, Home, Cell

Person responsible for account (Please provide documentation of financial POA)

Name, Mailing Address, City, State, Zip	Relationship	Phone Number Work, Home, Cell

Trinity Center

Financial Statement

Monthly Income - Applicant		Spouse (if applicable)	
1. Social Security	$_____	1. Social Security	$_____
2. Pension	$_____	2. Pension	$_____
3. Interest & Dividends	$_____	3. Interest & Dividends	$_____
4. Other Income	$_____	4. Other Income	$_____
Monthly Total (Add lines 1-4)	$	Monthly Total (Add lines 1-4)	$

Assets and Liabilities

A. Assets owned jointly and separately by the admitting applicant and other person(s) which are available to the applicant only:

1. Real Estate $_____

2. All other assets (ie: stocks bonds, mutual funds, savings accounts, Certificate of Deposits, Etc.) $_____

3. Less: Off-Setting Liabilities $_____

Net Assets owned which are available to the applicant only $_____

B. Long Term Care Insurance (for the admitting applicant only)

Name of Insurance Company _____

Address _____ City _____ State _____ Zip _____

Phone _____ Policy # _____

$_____ Per day for _____ Years _____

C. Other asses in which the admitting applicant has an interest (Describe property and interest held)

_____

_____

Trinity Center

I certify that the information I have provided in the foregoing application is true and correct and that I am signing as the responsible party. I have either been authorized to provide the information contained in this application or am acting as the applicant's guardian and/or conservator. I understand that the Trinity Center at Luther Park Community is relying on the accuracy of the information provided in this application in order to make a decision on admission. I understand and agree that any misrepresentation of any information provided in this application is grounds for rejection of this application. I further understand and agree that if any misrepresentation of any information provided in this application is discovered after admission, and admission would not have been granted if the correct information had been provided. The Trinity Center at Luther Park Community reserves the right to pursue any legal, equitable, or other remedies it may have against the applicant and/or responsible party signing the application below on behalf of the applicant.

I further understand that the Trinity Center at Luther Park Community is committed to promoting good health and safety among its residents and, therefore, SMOKING BY RESIDENTS IS PROHIBITED ON FACILITY PROPERTY.

Signature: _____

Date: _____

Trinity Center

Pre-Admission Checklist

- [ ] Complete the Application for Admission.
- [ ] Sign the Authorization to Release Healthcare Information form allowing us to obtain relevant medical records.
- [ ] Provide a copy of any paperwork for Power of Attorney, Guardian/Conservator, or Advance Directives such as a Living Will if applicable.
- [ ] Bring Medicare, Social Security, and any other supplemental insurance cards so that we can make a copy of both the front and the back. We will also need a policy number for any long-term care insurance.
- [ ] Schedule a nursing assessment with our Director of Admissions. Our nurse will visit your loved one at his/her current setting to determine if we are able to meet his/her needs. Upon completion of both the nursing assessment and Application for Admission, we will promptly notify you if your loved one qualifies for admission.
- [ ] A History & Physical examination will need to be completed by a physician or physician-extender within 90 days prior to admission.
- [ ] Do not refill prescriptions prior to admission. You will not be able to bring medications from home. Ask your pharmacy for a partial refill (for example a 7-day supply) if your loved one will run out of medications prior to admission. While you will have a choice of pharmacy at Trinity Center, the pharmacy must utilize a unit-dose delivery system, have a pharmacist on call 24 hours/day, and provide delivery service 7 days/week. Medications from the Veteran's Administration Pharmacy are accepted.
- [ ] Arrange the date for admission. Our Director of Admissions will work with you to schedule the day, time, and mode of transportation for admission.

Admission

- A member of our admissions team will meet with the Power of Attorney / Guardian or Responsible Party either in advance of admission or at the time of admission to complete admission paperwork. Paperwork will include items such as the Admission Agreement as well as Advance Directives. Paperwork can be emailed or faxed if needed.
- An initial 30-day payment will be collected at the time of admission.
- Share with your loved one as much or as little information as you deem appropriate. You may choose to tell him/her the day of the move. We suggest you keep it simple, "Mom, today you are moving to your new home." Avoid lengthy explanations as they are typically not understood and can lead to frustration. Don't hesitate to ask the Director of Admissions for advice as we have helped many families navigate this process.
- Comfortable clothing is preferred, i.e. items that are easy for the resident to get on and off. Please bring 7-10 days of washable clothing including undergarments, pajamas, and a good fitting pair of walking shoes. All items will be labeled and inventoried by staff. Please make sure all of the resident's clothes are marked before putting them away. If you desire to do your loved one's laundry, you will need to provide a hamper and lid with fire retardant coding.
- Feel free to personalize your loved one's room with pictures, radio, chair, etc. We discourage you from bringing difficult to clean items, collectibles, and valuables. It is by rule of the State Fire Marshal that no extension cords, multi-plug outlets, electric heaters, or heating pads/ blankets are allowed in a resident's room. If any items do not comply with safety and fire code regulations, you will be asked to remove them. Please feel free to ask us about any items you are considering.

Trinity Center

Authorization To Release Healthcare Information

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Trinity Center At Luther Park

Address: 1555 Hull Ave.

City: Des Moines State: IA Zip Code: 50316

Fax: 515-262-7338

This request and authorization applies to:

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Billing records
- ☐ Abstract/Summary
- ☐ Pharmacy/prescription records
- ☐ Other (describe specifically) _____

_____

*Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws unless sent directly to a physician's office from this facility. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) Date

_____ _____

Printed name of patient representative (i.e. parent, guardian, power of attorney for healthcare, executor) Representative's authority to sign for patient,