APPLICATION FOR ADMISSION

to

MEADOWS HOME

A Skilled Nursing Facility

and a division of

New Mexico Behavioral Health Institute at Las Vegas

located at

3695 Hot Springs Blvd.

Las Vegas, New Mexico 87701

The Department of Health, New Mexico Behavioral Health Institute at Las Vegas, and Meadows Home do not discriminate based on race, color, national origin, sex, religion, age, or disability in employment or the provision of services, programs, or activities.

REFERRAL INSTRUCTIONS

1. Each applicant must complete an application for admission. This includes medical records from within the past 30 days.

2. It is highly advisable for applicant's and family to visit the facility prior to the final decision being made regarding placement. It is understood that this may not always be possible, but every effort should be made to do so.

3. All referral material must be submitted to Meadows Home and will be reviewed by members of the Admission Review Committee. Consideration for admission will begin after all the relevant information has been received and reviewed.

4. Financial disclosure and arrangements are a vital part of the admission process, and the reimbursement officer usually works with the applicant/interested party so that an equitable reimbursement plan can be developed.

5. All applicants who are Medicaid recipients, or who have a Medicaid application pending must be reviewed prior to admission for level of care determination. Level of care will be determined by the members of the Admission Review Committee through review of documents provided with the admission packet. Meeting the requirements for the appropriate level of care does not automatically grant approval for admission to the facility as admission decisions are also based on the appropriateness of available beds and units.

6. Each referral is evaluated individually for appropriateness of the applicant for admission to the facility. We are prohibited by Federal Regulations from admitting anyone who requires services that we are not able to provide. Should an applicant require services not available with this facility, his/her application will be rejected, and the applicant informed of this decision.

7. All correspondence and other communication regarding referrals and/or admissions must be addressed to Meadows Home, 3695 Hot Springs Blvd., Las Vegas, NM 87701, Attention: Sam Garcia.

8. When beds are available, the referral process normally takes one to two weeks, depending primarily upon the completeness of the referral material, and the complexity of the case. Therefore, it is essential to submit applications as early as possible.

9. Contact:

   SAM GARCIA
   MEADOWS HOME ADMISSIONS
   3695 HOT SPRINGS BLVD.
   LAS VEGAS, NEW MEXICO 87701
   (505) 454-2388 (Voice)
   (505) 454-2229 (Fax)
   Samuel.Garcia2@doh.nm.gov (email)

PRE-ADMISSION DATA

FULL NAME OF APPLICANT:

_____

CURRENT ADDRESS:

_____

GENDER: _____ DATE OF BIRTH: ____/____/_____ AGE: _____

BIRTHPLACE: _____

SOCIAL SECURITY #: _____ - _____ - _____

MARITAL STATUS: S M D W SEP

1. Has applicant ever been in a nursing home before? ☐ **YES** ☐ **NO**
   If yes, when, and where?
   _____
2. Is the applicant in voluntary agreement with being placed at LTCD? ☐ **YES** ☐ **NO**
3. Has placement been attempted at a facility closer to the applicant's home or relatives' home? ☐ **YES** ☐ **NO**
   If yes, when, where and why was placement not made.
   _____
   _____
   _____

Does any person hold a formal guardianship or conservatorship for the applicant?

- GUARDIANSHIP (Plenary/Limited/Treatment/Temporary) ☐ YES ☐ NO
  IF YES, BY WHOM: _____
- CONSERVATOR SHIP ☐ YES ☐ NO
  IF YES, BY WHOM: _____
- POWER OF ATTORNEY ☐ YES ☐ NO
  IF YES, BY WHOM: _____
- SURROGACY ☐ YES ☐ NO
  IF YES, BY WHOM: _____
- OTHER _____ ☐ YES ☐ NO
  IF YES, BY WHOM: _____

Primary Contact Person or Interested Party:

NAME: _____ RELATIONSHIP: _____

ADDRESS: _____

TELEPHONE #: HOME: ( ) _____ WORK: ( ) _____

_____ _____
THIS PAGE COMPLETED BY: **DATE:**

_____
RELATIONSHIP TO APPLICANT:

APPLICANT PROFILE

APPLICANT NAME: _____ AGE: _____

GENDER: ☐ MALE ☐ FEMALE

ACTIVITY LEVELS	ALONE	NEEDS HELP	NOT AT ALL
WALKS	_____	_____	_____
USES WALKER	_____	_____	_____
USES WHEELCHAIR	_____	_____	_____
IN & OUT OF BED	_____	_____	_____
IN & OUT OF CHAIR	_____	_____	_____
IN & OUT OF BATHROOM	_____	_____	_____
DRESSES & UNDRESSES	_____	_____	_____
HYGIENE & GROOMING	_____	_____	_____

ELIMINATION

- **BLADDER** ☐ CONTINENT ☐ INCONTINENT ☐ CATHETER
- ***BOWEL*** ☐ CONTINENT ☐ INCONTINENT ☐ COLOSTOMY

NUTRITION AND HYDRATION

FOOD:

☐ EATS WELL ☐ EATS POORLY ☐ TUBE FEED
☐ FEEDS SELF ☐ NEEDS HELP ☐ MUST BE FED
☐ DIFFICULTY CHEWING ☐ DIFFICULTY SWALLOWING

SPECIAL DIET: _____

FLUIDS:

☐ TAKES FLUIDS WELL ☐ NEEDS ENCOURAGEMENT ☐ WILL NOT DRINK
☐ DRINKS ALONE ☐ NEEDS ASSISTANCE ☐ TUBE HYDRATED

LIST ANY KNOWN FOOD ALLERGIES OR DISLIKES BELOW:

_____

_____

_____

APPLICANT PROFILE (CONTINUED)

APPLICANT NAME: _____

COMMUNICATION	NORMAL	IMPAIRED	ABSENT	COMMENT
SPEECH	_____	_____	_____	_____
SIGHT	_____	_____	_____	_____
HEARING	_____	_____	_____	_____
READS	_____	_____	_____	_____
WRITES	_____	_____	_____	_____
SIGN LANGUAGE	_____	_____	_____	_____

PRIMARY LANGUAGE SPOKEN & UNDERSTOOD: _____

OTHER LANGUAGE(S) SPOKEN & UNDERSTOOD: _____

ATTITUDE AND BEHAVIOR

□ ALERT	□ CALM	□ ORIENTED	□ RESPONSIVE
□ MEMORY GOOD	□ HAPPY	□ OUTGOING	□ COOPERATIVE
□ QUIET	□ SLEEPS WELL	□ EASY TO EXCITE	□ MOODY
□ DEPRESSED	□ ANGRY	□ HOSTILE	□ STRIKES OUT
□ VIOLENT	□ RUNS AWAY	□ MEMORY POOR	□ DISORIENTED
□ UNHAPPY	□ AWAKEN FREQ.	□ UNCOOPERATIVE	□ CRIES EASILY
□ COMPLAINS	□ WITHDRAWN	□ COMBATIVE	
□ LIKES TO BE AROUND OTHERS		□ WANDERS AT NIGHT	
□ PREFERS TO BE BY SELF			

COMMENTS:

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____

THIS PAGE COMPLETED BY: **DATE:**

_____

RELATIONSHIP TO APPLICANT:

MEADOWS HOME
3695 HOT SPRINGS BLVD.
LAS VEGAS, NEW MEXICO 87701

MEDICAL HISTORY

APPLICANT NAME: _____

CHIEF COMPLAINT:

PRESENT ILLNESS:

(PAST HISTORY)

MEDICAL: _____

ALLERGIES: _____

SURGICAL: _____

TRAUMATIC: _____

FAMILY HISTORY: _____

DRUGS – PRESCRIBED:

1. _____
2. _____
3. _____

NON-PRESCRIBED:

1. _____
2. _____
3. _____

REVIEW OF SYSTEMS

GENERAL:

_____

_____

OPTHALMALOGICAL: _____ AUDITORY: _____
CARDIOVASCULAR: _____ UROLOGICAL: _____
RESPIRATORY: _____ NEUROLOGICAL: _____
GASTROINTESTINAL: _____ ENDOCRINOLOGICAL: _____
OB-GYN: GR. _____ PARA. _____ AB. _____
LMP: _____/_____/_____

PROBLEMS:

_____

PHYSICIAN'S SIGNATURE **DATE**

PHYSICIAN'S PRE-ADMISSION SCREENING

I, _____, a licensed physician, have examined _____ and have found him/her to be free of active tuberculosis or clinical symptoms of any other communicable/infectious disease.

My opinion is based on:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

PHYSICIAN'S SIGNATURE **DATE**

ADMISSION AGREEMENT Page 1 of 2

APPLICANT NAME: _____ **DOB**: _____/_____/_____

I consent to admission to Meadows Home, a division of New Mexico Behavioral Health Institute at Las Vegas, a Joint Commission accredited facility. I acknowledge that I will be under the care of an attending physician(s) and the colleagues of such physician(s). I understand and agree with the conditions of admission listed below.

I. Consent for Care and Treatment

A. Consent for Routine Care

I hereby consent to routine nursing, medical, and mental health care ordered by the attending physician and/or designated alternate. Examples of such routine care include bowel care, medications for constipation, mild diarrhea, indigestion, relief of mild pain and fever, diuretics, vitamins, minerals, topical anti-infective medications, I&O catheterization for urinalysis, sunscreen, skin care, nail care, special shampoo, diet/snacks, routine oral examinations, routine audiological examinations, routine diabetic monitoring, physical, occupational and speech therapy baseline assessments, psychiatric evaluations and treatment and routine assessments for capacity and diagnostic purposes, adjustments in medication within regulated ranges, routine diagnostic laboratory procedures and routine radiological procedures, and recreational outings.

B. Consent for Treatment and Diagnostic or Therapeutic Procedures

I understand that assessment of cognitive capacity, certification of emergency mental health evaluation for psychiatric hospitalization, and application for emergency psychotropic medications may be conducted under New Mexico law either with or without consent. I understand that each applicant or his/her legal representative has the right to consent or to refuse to consent to any proposed treatment, or diagnostic or therapeutic procedures. No applicant will be involved in any experimental procedure without his/her or the legal representative's full knowledge and consent. I understand that the medication regime of each applicant is monitored by registered pharmacists on a continuous basis and that the physician is immediately notified of any potential interactions or adverse effects.

I understand that ***specific consent will be obtained*** prior to specialized treatment and diagnostic or therapeutic procedures. Examples of such include but are not limited to sleep medication, anti-hypertensive medication, heart medications, diuretics, anticoagulants, antipsychotic medications, antidepressants, anti-anxiety medications, mood stabilizers, psychotherapy, specialized evaluations such as neuropsychological or personality assessments, specialized psychological treatment, or services such as treatment of posttraumatic stress disorder, psychological services provided by interns under supervision, special dental procedures, vision examinations, invasive radiological procedures, podiatry, and restraints.

I understand that if the physician decides that starting treatment immediately is needed to give applicant's physical or mental health, treatment will be started immediately, and the guardian (if applicable) will be notified as soon as possible.

ADMISSION AGREEMENT Page 2 of 2

II. Release of Information

I authorize Meadows Home to disclose all or any part of my record (in accordance with the applicable policy and law) to health care facilities to which I may be transferred or to any entity that may be liable to Meadows Home for all or part of the facility's charges.

III. Personal Valuables

I understand that it is advised that I send valuables home or deposit them with Meadows Home for temporary safekeeping and security until alternative arrangements can be made.

IV. Personal Furnishings and Equipment

I understand that I am allowed to keep personal possessions and equipment of my choice. I also understand that any possessions kept by me at the time of admission or acquired during my stay will be my sole responsibility. Meadows Home bears no responsibility or liability for injuries, property damage or losses which may result from the safekeeping of my possessions.

"I certify that this form has been explained to me, I have read the contents of the form, or the contents have been read to me. I understand its contents and all items not applicable were stricken before I signed".

_____ _____
Signature of Applicant **Date**

_____
Witness

Applicant cannot consent or authorize because:

_____

_____

_____ _____
Signature of Legal Representative **Date**

_____
Witness

REQUEST FOR FINANCIAL DOCUMENTATION

APPLICANT NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

You have been listed as the responsible party for the above – named applicant who was recently admitted to our facility. State Statute (NMSA 43-1-25 91978) states that "Applicants who are indigent may receive care and treatment at state-operated facilities without charge. The governing authorities of such facilities may require payment for the cost of care and treatment from all others pursuant to established fee schedules based on ability to pay." This facility requires that resources available to the applicants, includes, but is not limited to, Social Security, Railroad Retirement, Veterans Pension, other retirements, wages from employment, and insurance(s), be applied toward the applicants bill based on the sliding fee scale.

Please complete the attached financial documents for this applicant and return them to us within 15 days of receipt. If this applicant has any type of health insurance coverage, please also send the necessary insurance claim forms to this office for us to bill for the services the applicant receives at our facility.

Thank you for your assistance.

Sincerely,
NMBHI Finance Department

FINANCIAL AND PAYMENT CONTRACT

CONFIDENTIAL

APPLICANT NAME: _____

SOCIAL SECURITY #: _____

Address: 3695 Hot Springs Blvd. City: Las Vegas State: NM Zip: 87701

Work Phone: 505-454-2100

Amount of applicant's monthly benefits: $ (Social Security Benefit)

Monthly allowable for personal trust account: -$ 91.00 (Personal Spending Money)

Responsible Party: _____

Monthly care and maintenance contract amount: $ (Estimated amount due to monthly MCC to NMBHI)

Payment Plan: I understand that I will be responsible for a monthly Patient Responsibility. I acknowledge this is an estimated amount and is subject to change. I have also been informed that the daily rate for care and support for NMBHI is $425.94.

- I hereby authorize the NMBHI to release medical and financial information as is necessary for processing my third-party reimbursement claim to the parties identified, including, but not limited to, Social Security, Veterans, Railroad, Medicare, Medicaid, and/or public or private insurers.
- I, the undersigned, hereby agree to pay the charges for treatment at NMBHI as per the above payment plan of Federal and State Law and Regulations. These charges will be based on established rates for treatment of services and as reduced by third party reimbursement, or provisions of Federal or State Law and Regulations. I understand NMBHI does not have the authority to forgive debts owed to the State of New Mexico, and hereby authorize the acknowledgment of my account with NMBHI or to their designated credit and collection representative to allow for collection of delinquent accounts.
- I also agree that my financial commitment to NMBHI will be maintained monthly, and I understand that failure to comply may result in the discharge of the above-mentioned applicant, subject to and pursuant to all applicable Federal and State Laws and Regulations.

Patient trust balances will be properly distributed to the designated beneficiaries listed on this financial agreement. The beneficiary or beneficiaries shall receive equal amounts of the balance in the patient trust account upon death of the above-named applicant. This disbursement will be completed after the financial audit has been completed.

Beneficiary Name_____ **Address**_____ **Ph:**_____
Beneficiary Name_____ **Address**_____ **Ph:**_____
Beneficiary Name_____ **Address**_____ **Ph:**_____

Applicant/Responsible Party Signature: _____

_____ _____
Print Name and Relationship/Title **Date**

MEADOWS HOME
3695 HOT SPRINGS BLVD.
LAS VEGAS, NEW MEXICO 87701

PATIENT FINANCIAL QUESTIONAIRE

APPLICANT NAME: _____ SOCIAL SECURITY #: _____

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

Medicare Coverage ☐ Yes ☐ No Medicare Claim Number: _____
Part A Effective Date: _____
Part B Effective Date: _____

Medicare D Coverage ☐ Yes ☐ No Medicare D Claim Number: _____
Prescription Drug Coverage Group Number: _____

Medicaid Coverage ☐ Yes ☐ No Medicaid Number: _____

Health Insurance ☐ Yes ☐ No Provider Name: _____
Policy Number: _____
Group Number: _____
Holder: _____

APPLICANT INCOME

Social Security Benefits: _____ Retirement Benefits: _____
Civil Service Benefits: _____ Interest Income: _____
Railroad Retirement Benefits: _____ Dividends: _____
Veterans Pension: _____ Rental Income: _____
SSI Income: _____ Other Income:_____
Property Owned: _____ Value Property: _____
Checking Account: _____ Savings Account: _____

EXPENSES

Rental Expenses: _____ Vehicle Payment: _____
Mortgage Expenses: _____ Food Bill: _____
Medical Bills: _____ Insurance Expenses: _____
Utility Expenses: _____ Other Expenses: _____

Life Insurance: ☐ Yes ☐ No Provider Name: _____

Term Insurance_____ Whole Insurance_____ Irrevocably Assigned Policy_____
_____

Value: _____ Cash Value: _____

If you do not show any income for applicant, what has been his/her means of support?

_____

I, the undersigned applicant, responsible party, guardian, do hereby certify that the forgoing information is complete, true, and correct to the best of my knowledge. I also agree to provide documentation necessary for verification purposes.

Signature: _____ Date: _____
(Applicant/Legal Representative)

Print: _____ Date: _____
(Name/Title)

STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO PROVIDER, PHYSICIAN AND APPLICANT

APPLICANT NAME: _____ HOSPITAL #: _____

SOCIAL SECURITY #: _____

I certify that the information given by me in applying for payment under Title 18 and Title 19 of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare, Medicaid, and private insurance claims.

I request that payment of authorized benefits be made to me or on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare, Medicaid, and private insurance for payment on my behalf.

Signature: _____ Date: _____
(Applicant/Legal Representative)

Print: _____ Date: _____
(Name/Title)

REQUEST TO HANDLE PERSONAL FUNDS

APPLICANT NAME: _____ HOSPITAL #: _____

SOCIAL SECURITY #: _____

☐ I hereby request that Meadows Home assume the responsibility of holding and accounting for my personal funds. I also request that the facility hold in trust for me the amount of my monthly personal needs and allowance, and to make monthly withdrawals for care and maintenance from monthly income sources.

I also authorize Meadows Home to expend on my behalf, when authorized by me or my representative, funds in the facility's trust for items necessary for my personal needs not provided as covered services of this facility or by Title XIX – Medicaid.

☐ I do not request that Meadows Home assume the responsibility for my own personal funds, therefore, relieving the above-named facility of any responsibility related to the holding or accounting for my personal funds.

Signature: _____ Date: _____
(Applicant/Legal Representative)

Print: _____ Date: _____
(Name/Title)

VOLUNTARY STATEMENT OF PARTICIPATION, SSI/SS

I, _____ voluntarily submit that I currently receive Supplemental Security Income and/or Social Security Benefits.

My Social Security Number is: _____

My Home Address is: _____

_____

Date of Admission: _____

We the undersigned state that we are personally acquainted with the above-named applicant who is unable to sign his/her name, his/her mark has been affixed by way of signature in our presence, and we accordingly witness his/her signature by mark at the applicant's request and have written his/her name alongside his/her mark in his/her presence. We state further that the contents of this document were read and explained to him/her and that he/she indicated full understanding and assent.

Applicant Signature: _____ Date: _____

If the applicant is unable to sign, the legal representative may sign below:

Signature: _____ Date: _____
(Legal Representative)

Print: _____ Date: _____
(Name/Title)