Swing Bed Intermediate Pre-Admission Application

DEMOGRAPHIC INFORMATION

Resident Name: _____ Date of Birth: _____

Age: _____ Gender: Male Female Social Security Number: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Primary Language: _____

Current Living Situation: ☐ Lives alone ☐ Lives with Family Member ☐ Other Facility

Facility Name: _____

Living Will: ☐ Yes ☐ No

Power of Medical Attorney: ☐ Yes ☐ No Power of Financial Attorney: ☐ Yes ☐ No

Primary Provider Name: _____ Hospital Affiliation: _____

Primary Insurance Provider: _____ Policy Number: _____

Secondary Insurance Provider: _____ Policy Number: _____

Medicare Plan: ☐ Medicare A&B ☐ Humana ☐ United Health ☐ BCBS

Plan Number: _____

Medicaid Plan: _____ Plan Number: _____

Anticipated Date of Admission Needed: _____

RESONSIBLE PARTY / GUARANTOR INOMRATION

Name: _____ Relationship to Resident: _____

Mailing Address: _____ City: _____ State: _____ Zip Code: _____

Physical Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone Number: _____

Legal Representative: ☐ Yes ☐ No Type of Representation: ☐ POA ☐ Guardian ☐ Conservator

Preferred Method of Communication: ☐ Phone ☐ Email ☐ Text ☐ In-Person

Best Time to Contact: ☐ Morning ☐ Afternoon ☐ Evening

P: 406-632-4351 · F: 406-632-3174 · 25 US Highway 191 North · Harlowton, MT 59036

NEEDS ASSESSMENT

Assistive Devices Used:	☐ None ☐ Cane ☐ Walker ☐ Wheelchair Other: _____
Dietary Restrictions:	☐ None ☐ Yes (list): _____
History of Falls in the past year:	☐ None ☐ Yes, Number of Falls: _____ Falls Resulted in Injury? ☐ No ☐ Yes (list): _____
Need assistance with:	☐ Bathing ☐ Toileting ☐ Mobility ☐ Medication Management ☐ Meals ☐ Dental/Oral Care ☐ Bowel & Bladder Control ☐ Catheter/Ostomy Care

CURRENT CARE NEEDS

Personal Care – Grooming/Bathing

Bathing ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

Dental/Oral Care ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

Shaving ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

Nail Care ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

Hair Care ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

Personal Care - Toileting

Bladder/Bowel Control? ☐ Yes ☐ No Special Equipment Required? _____

Catheter/Ostomy? ☐ Yes ☐ No

Dietary

Eats Meals Daily ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

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Meal Preparation ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

Chewing/Swallowing ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

Recent Weight Loss/Gain? ☐ Yes ☐ No	Uses Feeding Tubes/Devices? ☐ Yes ☐ No
Uses Feeding Tubes/Devices? ☐ Yes ☐ No	Special Diet Followed? ☐ Yes ☐ No

Mobility

Ambulatory ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

Transfer To/From Bed ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

Transfer To/From Chair ☐ Performs Independently ☐ Requires Some Assistance ☐ Totally Dependent

Comments: _____

Elopement Risk? ☐ Yes ☐ No

Behavior/Mental Health

Orientation to Date, Day, Place ☐ Well Oriented ☐ Some Lapse in Memory ☐ Needs Assistance

Comments: _____

Wanders or Confusion ☐ Well Oriented ☐ Some Lapse in Memory ☐ Needs Assistance

Comments: _____

Memory/Recall ☐ Well Oriented ☐ Some Lapse in Memory ☐ Needs Assistance

Comments: _____

Judgement ☐ Well Oriented ☐ Some Lapse in Memory ☐ Needs Assistance

Comments: _____

Follows Instructions ☐ Well Oriented ☐ Some Lapse in Memory ☐ Needs Assistance

Comments: _____

Sociability ☐ Well Oriented ☐ Some Lapse in Memory ☐ Needs Assistance

Comments: _____

Sad or Anxious Mood? ☐Yes ☐No	Socially Inappropriate/Disruptive? ☐Yes ☐No
Diagnosed or Treatment History for Mental Illness or Developmental Disability? ☐Yes ☐No	
Transportation	
Can Drive Self? ☐Yes ☐No	Can Leave the Facility with Assistance? ☐Yes ☐No

HEALTH PROBLEMS - Check all that apply

	Prescription Medications	**Dosage**	**Pharmacy**
Anemia			
Arthritis & Other Joint Limitations or Injuries			
Bowel/Bladder Problems			
Cancer, Leukemia or Tumor			
Dementia (Alzheimer's, Huntington's)			
Diabetes			
Digestive Disorder (Ulcers, Diverticulosis, Celiac Disease)			
Edema (swelling)			
Effects of Stroke (CVA, TIA, Memory Loss)			
Osteoporosis or Fractures			
Poor Circulation			
Hearing Impairments (Hard of Hearing, Deafness)			
Heart Problems (Angina, CHF, Heart Attack, High Blood Pressure)			
Respiratory Problems (Asthma, COPD, Emphysema)			
Skin Problems (Ulcers, Lesions, Wounds, Rashes)			
Visual Impairments (Cataracts, Glaucoma, Blindness)			
Surgeries with residual side effects (Drainage, Amputation, Paralysis, Pain, Fatigue)			
Other:			
Non-Prescription Medications:			

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FINANCIAL INFORMATION

Each applicant must attach a copy of the most recent bank statement(s) and/or securities statement, and the local tax assessment on real or personal property for verification purposes. Should the financial situation change while residing in the swing intermediate unit, you will be expected to notify Patient Financial Services.

Name of Bank(s) Branch	Checking	Savings	Name on Account(s)	Relationship

FINANCIAL RESOURCES – Check all that apply

Applicant Income	Amount Received per Month	Spouse Income	Amount Received per Month
Public Assistance	$_____	Public Assistance	$_____
Supplementary Security Income	$_____	Supplemental Security Income	$_____
Longevity Income	$_____	Longevity Income	$_____
Social Security	$_____	Social Security	$_____
Veterans Benefit	$_____	Veterans Benefit	$_____
Retirement Annuity	$_____	Retirement Annuity	$_____
Pension	$_____	Pension	$_____
Checking Account Balance	$_____	Checking Account Balance	$_____
Savings Account Balance	$_____	Savings Account Balance	$_____

PAYMENT & BILLING DETAILS

Payment Method ☐ Private Pay ☐ Medicaid Pending ☐ Medicaid Approved ☐ Insurance

Other: _____

OTHER RESOURCES

Other Resource	Value	Legal Owner
Real Property (Land & Buildings)	$_____	_____
Vehicles, Boats, Airplane	$_____	_____
Stocks & Bonds	$_____	_____
_____	$_____	_____
_____	$_____	_____
_____	$_____	_____

What Assets have you bought, sold, traded, or given away anything of value within the past 5 years >$500.00?

Asset	Change	Value	Legal Owner

Any other information pertinent to this application?

_____

_____

CERTIFICATION SIGNATURES

I certify that to the best of my knowledge, the information in this application is true and correct.

Printed Name: _____

Applicant's Signature: _____ Date: _____

If POA or Family Member Completed: Relationship: _____

Printed Name: _____

Signature: _____ Date: _____

Internal Use

Date Application Received:	_____	By Whom:	_____
Date Application Reviewed by Care Coordinator:	_____	By Whom:	_____
Date Application Reviewed by Business Office Manager:	_____	By Whom:	_____
Date Application Reviewed by Director of Nursing:	_____	By Whom:	_____
Date Application Reviewed by Medical Director:	_____	By Whom:	_____
Date of Planned Admission:	_____	By Whom:	_____

Communication Measures

Date to Nursing Staff:	_____	By Whom:	_____
Date to EVS:	_____	By Whom:	_____
Date to Facilities:	_____	By Whom:	_____
Date to Dietary/Dietician:	_____	By Whom:	_____
Date to Pharmacist Consultant:	_____	By Whom:	_____