To whom it may concern,

We appreciate your interested in becoming a resident of Glendive Medical Center Extended Care Facility. Our facility is a 36 bed facility for resident in need of intermediate nursing care. Our facility serves people of all ages who need short term or long-term care. In addition to a competent and compassionate staff and a high quality of care, we offer quality of life for our residents.

For our team to evaluate your eligibility and needs of our facility, we need some information about you. The information in this application will be used by Glendive Medical Center - Extended Care Staff. No other use, specifically authorized by law, will be made of this information without my prior consent. I also understand that I am under no obligation to supply the information requested by this form, however, my eligibility cannot be determined without providing such information and the consequences of such a refusal would make me ineligible for admission.
Please provide the following information:

- Completed facility application (document is attached)
- A copy of any advance directives: *living will, medical power of attorney, financial power of attorney, POLST form*
- A copy of all insurance cards: *Medicare, supplement, prescription drug card, long term care policy information, Medicaid*
- Medical records; if your coming from a hospital or another facility, please contact the facility representative about sending records to our facility. Records can be faxed to 406-345-3325, ATTN: Social Services. Information needed from facility – *History and Physical, Provider progress notes, nursing notes, medication list, therapy notes if applicable.* If your receiving care at Glendive Medical Center or Gabert Clinic our facility will be able to access your records.

Once all the information is received, the referral will be reviewed by our facility's admission committee to determine if the prospect resident is appropriate for our facility and if we're able to meet the individuals needs. Social Services will be in contact with you regarding the determination.
Please note that completion of the "pre-admission" form does not guarantee placement at the Glendive Medical Center Extended Care.

If you have any questions, please feel free to contact:

Christina Sager, SS

Glendive Medical Center
Social Services
Phone: 406-345-3338
Fax: 406-345-3325
Email: csager@gmc.org

Revised 12/2021

Applicant/Resident Information:			
Name:	DOB:	Age:	Sex:
Address:	County:	Phone: ( )	
Marital Status: Single Married Separated Divorced Widow	Birth Place:		

Social Security:	Medicare #:	Medicaid #:

Health Insurance #1:	Policy #:
Health Insurance #2:	Policy #:
Prescription Drug Plan (We may ask you to switch plans if we are not contracted):	

Attending Physician:	Last Seen by Physician:	Physician Phone #:
Applicant/Resident Likes to be Called (Nickname):		
Current Living Arrangements: ☐ House ☐ Apartment ☐ Other:		

Do you live alone? ☐ Yes ☐ No	Previous Occupation:
Education:	Spiritual/Religious Preference:
Cultural Background, if any:	Primary Language:
This Placement is: ☐ Short-Term ☐ Long-Term ☐ Other (explain)	
Veteran: ☐ Yes ☐ No If yes, which branch of service and dates:	

Legal Documentation: Do you have the following documents? (These must be sent with the application)		
☐ Durable Power of Attorney	☐ Durable Medical Power of Attorney	☐ Living Will
☐ Guardianship	☐ Conservator	☐ POLST/ Do Not Resuscitate
☐ Other Advanced Directives (list)		

Financially Responsible Party:			
Name:	Relationship:		
Home Phone: ( )	Business Phone: ( )		
Address:	City:	State:	Zip:
Send Statement/Bill To: (Name, Address, Phone)			

Family Information:	
Spouse Name:	☐ Living ☐ Deceased Date:

Children: (If more, list on back of form)		
Name:	Address:	Phone: ( )
Name:	Address:	Phone: ( )
Name:	Address:	Phone: ( )
Name:	Address:	Phone: ( )
Name:	Address:	Phone: ( )

Parents – Father's name:	Mother's name(& maiden name):
Occupations:	# of Siblings:
#of Grandchildren:	# of Great Grandchildren:

Main contact person while individual is a resident of facility:			
1. Name:		Relationship:	
Home/Cell Phone: ( )		Email Address:	
Address:	City:	State:	Zip:
2.Name:		Relationship:	
Home/Cell Phone: ( )		Email	
Address:	City:	State:	Zip:

Funeral Home Arrangements:		
Name:	City:	Phone:

Additional Information you would like us to know about the prospective resident:

Signature   Date

Witness   Date

Prospective Resident's Name: ________________________________Date: ________________

Tuberculosis Symptom Screening Questionnaire

Signs & Symptoms	YES/NO	Duration & Description
Prolonged cough (greater than 2-3 weeks)		
Chest pain		
Chills		
Fever		
Night sweats		
Loss of appetite		
Unexplained weight loss		
Weakness or fatigue		
Malaise (feeling of general discomfort/illness		
Diagnosis of community-acquired pneumonia that has not improved after 7 days of treatment		

******If cough of 2-3 weeks or greater, plus any one of the above symptoms/conditions, refer to provider. ******