



Thank you for your interest in Extended Care at Glendive Medical Center. It is my understanding that access to 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.

Room rates will be discussed with the prospective resident and his/her responsible party by Social Services. Pre-payment is required upon admission.

Admission procedures are based on the following:

- ◆ **A current application for admission completed by the perspective resident and/or the person who is responsible for handling the financial and/or medical affairs of the prospective resident.**
- ◆ A current (less than 5 days old) History and Physical.
- ◆ Once the information has been received, the application will be considered for admission. In rare circumstances, this form may be completed at the time of admission.
- ◆ Once the applicant has been approved, the responsible party will be notified and admission arrangements will be made at that time.
- ◆ **The following documents, if applicable, are needed prior to, or upon, admission: Financial Durable Power of Attorney, Medical Durable Power of Attorney, Guardianship, Conservatorship, Advance Directives, Living Wills, Physician Order for Life Sustaining Treatment (POLST), prescription card, Medicare card, and Medicare supplement card, a copy of photo ID and social security card.**
- ◆ If you have any questions, please, feel free to contact Social Services at (406)345-3338, Monday through Friday, between the hours of 8:00 a.m. and 5:00 p.m.

PLEASE NOTE THAT COMPLETION OF THE PRE-ADMISSION FORM DOES NOT GUARANTEE PLACEMENT AT GLENDIVE MEDICAL CENTER - EXTENDED CARE.



<b>Applicant/Resident Information:</b>			
Name:	DOB:	Age:	Sex:
Address:	County:	Phone: (    )	
Marital Status: S    M    Sep    D    W	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: <input type="checkbox"/> House <input type="checkbox"/> Apartment <input type="checkbox"/> Other:			
Do you live alone? <input type="checkbox"/> Yes <input type="checkbox"/> No	Previous Occupation:		
Education:	Spiritual/Religious Preference:		
Cultural Background, if any:	Primary Language:		
This Placement is: <input type="checkbox"/> Short-Term <input type="checkbox"/> Long-Term <input type="checkbox"/> Other (explain)			
Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, which branch of service and dates:			
<b>Legal Documentation:</b> Do you have the following documents? (These must be sent with the application)			
<input type="checkbox"/> Durable Power of Attorney	<input type="checkbox"/> Durable Medical Power of Attorney	<input type="checkbox"/> Living Will	
<input type="checkbox"/> Guardianship	<input type="checkbox"/> Conservator	<input type="checkbox"/> POLST/ Do Not Resuscitate	
<input type="checkbox"/> Other Advanced Directives (list)			
<b>Financially Responsible Party:</b>			
Name:	Relationship:		
Home Phone: (    )	Business Phone: (    )		
Address:	City:	State:	Zip:
Send Statement/Bill To: (Name, Address, Phone)			
<b>Family Members:</b>			
Spouse Name:		<input type="checkbox"/> Living <input type="checkbox"/> 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:

<b>In Case of Emergency, Notify:</b>			
Name:		Relationship:	
Home Phone: (    )		Business Phone: (    )	
Address:	City:	State:	Zip:
Name:		Relationship:	
Home Phone: (    )		Business Phone: (    )	
Address:	City:	State:	Zip:

<b>Funeral Home Arrangements:</b>		
Name:	City:	Phone:

<b>Additional Information:</b>

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Signature Date

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Witness Date