Allegan County Medical Care Facility
Admission and Inquiry Policy

Inquiry Policy:

Individuals inquiring about possible future needs for nursing home care will be sent a facility brochure, an Admission and Inquiry Policy, and a Waiting List Application form. Individuals are not added to the Facility Waiting List from an inquiry. A Waiting List Application form must be received by the facility to be added to the list. Facility tours are welcome.

Admissions Waiting List Policy:

The facility maintains an Admissions Waiting List for Allegan County residents who require nursing home placement for both skilled and basic levels of care. Applications are placed in one of three priorities on the list based on their current living status, medical condition, and rehabilitation needs. The priorities are summarized as follows:

Priority 1 (Served first): Applicants currently in an acute care hospital referred by the hospital itself. (The facility will contact the hospital at least weekly to maintain current with the applicant’s status.)

Priority 2 (Served after priority 1): Applicants at home, in adult foster care or assisted living facilities. These applicants must provide the Medical Care Facility with:

- A physician’s written referral for nursing home placement that includes current diagnoses and medications, including dosage and route of administration.
- A recent history and physical examination by the referring physician.
- The most recent chest X-ray report (Must be within 90 days of admission.)
- A preadmission screening (Form DCH-3877) completed by the referring physician.

(The facility will contact the applicant or the applicant’s representative periodically to update the status of the application.)

Priority 3 (Served after priorities 1 and 2): Applicants currently in a nursing home who desire to transfer to this facility.

**Note: An applicant’s priority may change repeatedly while waiting for a vacancy depending on their current status. For example: An applicant may be transferred from a nursing facility (priority 3) to a hospital. This would move that particular applicant into priority 1. If the same applicant is then transferred back to the nursing home, but still wishes to transfer to the Medical Care Facility when a vacancy becomes available, the applicant returns to priority 3.**
WAITING LIST APPLICATION

** In compliance with County ordinance, the facility is a smoke-free environment **

DATE _______________________________

NAME _______________________________  BIRTH DATE ________________ SEX _____

ADDRESS ____________________________________________________________________

SOCIAL SECURITY # __________________________ MEDICARE # __________________

MEDICAID # ____________________________ VETERAN # __________________

PRIVATE INSURANCE ________________________________________________________

NAME/ADDRESS OF LEGAL REPRESENTATIVE _______________________________________________________________________

INDICATE THE TYPE OF LEGAL OVERSIGHT (LIST ALL THAT APPLY)

_____ GUARDIAN _____ CONSERVATOR _____ DPOA HEALTH _____ DPOA FINANCIAL

LIST WHO SHOULD BE CONTACTED WHEN AN OPENING IS AVAILABLE:

NAME ______________________________________ RELATIONSHIP _________________

ADDRESS ____________________________________________________________________

HOME PHONE ________________ WORK/CELL PHONE ________________

NAME ______________________________________ RELATIONSHIP _________________

ADDRESS ____________________________________________________________________

HOME PHONE ________________ WORK/CELL PHONE ________________

DESCRIBE THE CURRENT LIVING SITUATION OF THE PROSPECTIVE RESIDENT. __________________________________________________________________

______________________________________________________________________________

WHY IS ADMISSION TO THE ALLEGAN COUNTY MEDICAL CARE FACILITY NEEDED/DESIRED? ____________________________________________________________

______________________________________________________________________________

IS THE PROSPECTIVE RESIDENT AWARE OF THIS APPLICATION? _____________

NAME OF REFERRING PHYSICIAN _____________________________________________

PHYSICIAN ADDRESS ________________________________________________________

PHYSICIAN PHONE __________________________________________________________

DATE OF LAST CHEST XRAY ________________ WHERE ________________

HAS THE APPLICANT EVER TESTED POSITIVE FOR TB? ________________________
DATES/PLACE OF LAST HOSPITALIZATION AND REASON

PREVIOUS NURSING HOME ADMISSIONS (LOCATION(S)/DATES)

MEDICAL CONDITIONS/DIAGNOSES

CURRENT MEDICATIONS

ANY CURRENT EVIDENCE OF:

- DEPRESSION
- CONFUSION
- HALLUCINATIONS
- PARANOIA
- AGITATION
- DEMENTIA
- MENTAL ILLNESS
- SUBSTANCE ABUSE

DESCRIBE ANY BEHAVIOR PROBLEMS AND WHEN THEY OCCUR

ALCOHOL/DRUG/TOBACCO USE

DIET RESTRICTIONS

ALLERGIES/DRUG REACTIONS

SKIN PROBLEMS (RASHES, PRESSURE SORES, ETC.)

OXYGEN USE

ASSISTIVE DEVICES USED:

- GLASSES
- HEARING AIDS, BOTH EARS, LEFT, RIGHT
- DENTURES, FULL, PARTIAL, UPPER, LOWER
- WALKER
- CANE
- WHEELCHAIR, OWNED BY APPLICANT? YES NO

ADDITIONAL INFORMATION
WHAT ASSISTANCE IS NEEDED FOR:

EATING:

___ INDEPENDENT—ABLE TO FEED SELF
___ MINIMUM—CONGREGATE MEALS, HOME DELIVERED
___ MODERATE—SET UP OF PLATE, OPENING OF ITEMS, CUTTING
___ MAXIMUM—SUPERVISION, CUEING NEEDED
___ TOTAL ASSISTANCE—DEPENDS ON OTHERS TO BE FED

BATHING:

___ INDEPENDENT—BATHES/SHOWERS SELF
___ MINIMUM—REQUIRES BATHING ITEMS SET UP
___ MODERATE—NEEDS PHYSICAL ASSISTANCE IN & OUT OF BATH
___ MAXIMUM—NEEDS PARTIAL “HANDS ON” ASSISTANCE
___ TOTAL ASSISTANCE—DEPENDS TOTALLY ON OTHERS FOR BATHING

MOBILITY

___ INDEPENDENT—MOVES AROUND WITH NO ASSISTANCE
___ MINIMUM—USES ASSISTIVE DEVICES (WALKER/CANE), NEEDS CUES SUPERVISION—STAND BY ASSISTANCE
___ MODERATE—NEEDS ONE PERSON TO PHYSICALLY ASSIST WITH MOVING
___ MAXIMUM—NEEDS TWO PEOPLE TO PHYSICALLY ASSIST WITH MOVING
___ TOTAL—DEPENDS COMPLETELY ON OTHERS, IS LIFTED

ELIMINATION

___ INDEPENDENT—USES THE BATHROOM WITHOUT ANY ASSISTANCE
___ MINIMUM—USES INCONTINENT PRODUCTS
___ MODERATE—OCCASIONAL INCONTINENCE, NEEDS VERBAL CUES
___ MAXIMUM—FREQUENT INCONTINENCE OF BOWEL/BLADDER, CATHETER
___ TOTAL—INCONTINENT, DEPENDENT ON OTHERS.

FALLS

___ NO FALLS IN THE LAST 12 MONTHS
___ ONE FALL IN THE LAST 12 MONTHS, WITHOUT INJURY
___ TWO OR MORE FALLS IN THE LAST 12 MONTHS, WITHOUT INJURY
___ TWO OR MORE FALLS IN THE LAST 12 MONTHS, WITH INJURY
___ FREQUENT FALLS, UNSAFE