Saint Margaret Hall

1960 Madison Road
Cincinnati, Ohio 45206

Carmelite Sisters
for the Aged and Infirm

Phone (513) 751-5880
Fax (513) 751-9813

In reply to your recent inquiry, the following information should be helpful. Please call the Admissions Office to make an appointment for a tour and/or to answer any questions you may have regarding this important process.

The daily cost is dependent on the level of care required and the type of accommodations. Note: Rates are for room and board and do not include ancillary charges such as supplies, therapy, physician fees, and medications.

Our first floor is **Assisted Living/Residential Care**. At this level of care, we offer assistance with medications, bathing and meals. Meals are provided in our main dining room.

The Daily Rates are as follows:

-Private room with ½ bath	$165.00
-Private room with full bath	$175.00

Suite prices available upon request

Our second and third floors are **Nursing Units**. At this level of care intermediate and skilled nursing care is provided. St. Margaret Hall is a Medicare and Medicaid provider for this level of care.

Prices range from $278.00 to $328.00 per day depending upon the type of room.

We require each applicant to complete an application for admission, which must be accompanied with a copy of the applicant's Social Security Card, Medicare Card, and all other applicable insurance information. (Please copy both sides of cards). We also require each applicant to submit a medical report from their primary care physician which must be updated within five days of admission.

There is a $200.00 application fee for our Assisted Living/Residential Care unit applicants. Please make checks payable to St. Margaret Hall.

Thank you for your interest in St. Margaret Hall. We hope we can meet and fulfill your needs. Please contact the Admission Office at 513-751-5880 with any questions you may have.

Sincerely,
St. Margaret Hall
Admissions Department

December 2018

St. Margaret Hall

1960 Madison Road
Cincinnati, OH 45206

APPLICATION FOR ADMISSION

Phone: (513) 751-5880
Fax: (513)751-9813

Date of Application: _____

Name of Applicant:_____ Maiden Name:_____

Current Address:_____Phone #: _____

How long have you resided at this address? _____
If less than 2 years please list previous address_____

Date of Birth:_____ Place of Birth:_____

Marital Status: M-W-S-D Spouse's Name:_____ If Deceased: When _____

If Living: Where _____

Religion:_____ Church: _____

Would you like your church notified of your Admission? ☐ Yes ☐ No

U.S. Citizen: ☐ Y ☐ N Years in U.S. _____ Years in City _____

Is the applicant a registered Sex Offender? ☐ Yes ☐ No

Social Security #: _____

Medicare #:_____
A: Medical Ins. Effective Date: _____
B: Hospital Ins. Effective Date: _____

Other Medical Insurance:_____ Policy #:_____
Medicaid #, if applicable: _____ Billing #:_____

PLEASE INCLUDE COPIES OF BOTH SIDES OF ALL INSURANCE CARDS WITH APPLICATION

MEDICAL INFORMATION

Primary Physician: _____

Address: _____ Phone #: _____

List Last Hospitalization: Where: _____ When: _____

List prior stays at other Health Care Facility/Nursing Home:

Where:_____ How Long:_____

NEXT OF KIN NOTIFICATION

Person of initial contact (Health Care)

Name Home Address Relationship
Home #: _____
Email Address: _____ Cell #: _____
Work #: _____

Name Home Address Relationship
Home #: _____
Cell #: _____
Work #: _____

Name Home Address Relationship
Home #: _____
Cell #: _____
Work #: _____

Name Home Address Relationship
Home #: _____
Cell #: _____
Work #: _____

Does applicant have a Financial Power of Attorney? □ Yes □ No If yes, Attach a Copy.
Does applicant have a Durable Power of Attorney for Health Care: □ Yes □ No If yes, Attach a Copy.
Does applicant have a Living Will? □ Yes □ No If Yes, Attach a Copy.

FUNERAL ARRANGMENTS- Person to Notify:

Name Home Address Relationship Home #: _____
Work #: _____

Funeral Home: - Name:_____ Phone #: _____

Address:_____ Cemetery: _____

****

I, undersigned, state that responses given on this application are complete, correct, and accurate to the best of my knowledge. I understand that falsification on this application may be cause for denial of admission or discharge thereafter.

Signed:_____ Relationship to Applicant: _____
SMH does not discriminate against any Resident/Applicant before, during, or after admission into the Home on the basis of race, color, creed, age, handicap, sex, national origin, or payor status.

Name: _____

To provide good continuity in care and make our Residents feel at home here, we will use the information below to write a brief profile or social history. Please answer all questions and add any information that may be helpful in getting to know Applicant.

FAMILY HISTORY: Parents Names, Brothers/Sisters Names(please indicate applicant's place in family and if siblings are living/deceased).

_____

_____

EDUCATION: Grade School_____ YR _____ High School _____ YR _____

College Degrees _____ YR _____

Veteran Yes _____ No _____ Military Service _____ Military Branch _____

WORK HISTORY: Occupation: _____Retirement Date: _____

Please describe career/ work history, include company(s) worked for, jobs and titles.

_____

_____

_____

Number of Grandchildren: _____ Number of Great Grandchildren: _____

SOCIAL INTEREST: (e.g. volunteer activities, hobbies, interest, organization, membership, church work, etc.)

_____

_____

Accomplishments/ Achievements: _____

How Does Applicant spend his/her day: _____

_____

What does Applicant do to reduce stress during crisis times: _____

Provide any unique information that would be helpful for staff to make applicant feel at home and assist with adjustment: _____

_____

THIS SPACE FOR ST. MARGARET HALL STAFF USE ONLY

Application received, checked, and deemed complete for processing by: _____Date: _____

NAME: _____

CUSTOMARY ROUTINE

Cycle of Daily Events	
Stays up late at night (e.g. after 9:00 P.M.)	
Naps regularly during the day (at least one (1) hour)	
Goes out 1+ days a week	
Stays busy with hobbies, reading, or fixed daily routine.	
Spends most time alone or watching T.V.	
Moves independently indoors (with cane, walker, crutches, etc., if used)	
Used Tobacco products at least daily- specify type amount.	
Eating Patterns	
Distinct food preferences- specify	
Eats between meals all or most days	
Used alcoholic beverage(s) at least weekly- type/ amount	
Hygiene Patterns	
In bed clothes most of the day	
Wakens to toilet all or most nights	
Has irregular bowel movement pattern- uses laxatives	
Prefers showers for bathing	
Prefers bathing in P.M.	
Involvement Patterns	
Daily contact with relatives/ close friends	
Usually attends church, temple, synagogue (etc.)	
Finds strength in faith	
Daily animal companion	
Involved in group activities	

FINANCIAL DISCLOSURE

We thank you for considering St. Margaret Hall. To aid us in assessing whether we can meet your financial needs, we would like to review your financial resources to pay for care. Once determined, we can then establish a clear understanding of the financial responsibility you will be undertaking.

We require this information of all residents, regardless of their method of payment or length of stay. Completing this form before admission day will aid us in helping you make the best decisions, and will expedite the admission process. All information will be kept confidential, and if you choose our facility, this form will become part of your admission agreement.

General Information:

Prospective Resident's Name:_____

If you are not the prospective resident:
Your Name: _____ Relationship:_____

Prospective Resident's Spouse: _____

Legal Representatives:

Please provide agreements designating each legal representative. (Example: Legal guardian, POA, DPOA, Guarantor, Responsible party)

Type of legal representative* _____

Name: _____ Telephone (day/eve): _____

Address:_____ Title or relationship to resident: ___

_____

Type of legal representative* _____

Name: _____ Telephone (day/eve): _____

Address:_____ Title or relationship to resident: ____

_____

Financial Information:

Does the resident have any insurance that will cover care provided in a long-term care facility, YES _____ NO _____ or residential care facility.

If yes, please identify:

Company: _____ Policy #: _____

Address: _____
Agents Name: _____ Telephone #: _____

Monthly Income:

Salary	$ _____	Social Security Check	$ _____
Pension	$ _____	IRA	$ _____
Annuity	$ _____	Disability Check	$ _____
Rental income	$ _____	Other	$ _____

Total Income- All sources $ _____

Cash Assets:

Bank (1) _____ Location _____

Checking account # _____ Balance in account $_____

Savings account # _____ Balance in account $ _____

Certificates of Deposit? NO ___ YES ___ If yes, approximate amount $ _____

Bank (2) _____ Location _____

Checking account # _____ Balance in account $_____

Savings account # _____ Balance in account $ _____

Certificates of Deposit? NO ___ YES ___ If yes, approximate amount $ _____

Bank (3) _____ Location _____

Checking account # _____ Balance in account $_____

Savings account # _____ Balance in account $ _____

Certificates of Deposit? NO ___ YES ___ If yes, approximate amount $ _____

(If there are additional assets, which require additional space, please list the location of these assets and the amount on a separate sheet and attach to financial disclosure)

Total of all cash assets listed $ _____

Real Estate Assets:

Does the resident own a home? No ____ Yes __ If yes, approximate value $ ____

Does the resident own any other property? No ___ Yes ___ If yes, approximate value $____

If yes, what and where is property located? _____

Total value of all properties owned $ _____

Life insurance Cash value:

Does resident have life insurance policies with cash value? No ____ Yes ____

Company Name: _____ Approximate amount of cash value $ _____

Agent Name: _____ Telephone _____

Annuities $ _____

(If life insurance is held by more than one agent, please list agents and the amount they handle on a separate sheet and attach to this financial disclosure.)

Total of all cash values listed $ _____

Securities:

Does the resident have stocks and bonds? No _____ Yes _____

Approximate current market value of all securities $ _____

Agent handling securities _____ Telephone _____

Address _____

(If more than one agent holds securities, please list these agents and the amount they handle on a separate sheet and attach to this financial disclosure.)

Assets Transferred To Or Held In Trust:

Identify assets held in Trust?: _____

On what date were assets transferred to Trust?: _____

Approximate value of assets held in Trust: _____

[Require Prospective Resident to Produce Copy of Trust Agreement]

Other:

Are there any other sources of income that have not been identified above?
No _____ Yes _____

Please identify the source(s): _____

_____

Approximate current market value of these sources $ _____

Total available sources of income:

Monthly income	$ _____
Annuities	$ _____
Total Sources of income	**$ _____ (A)**

Total available sources of assets:

Bank (1)	**$ _____**
Bank (2)	**$ _____**
Bank (3)	**$ _____**
Real Estate Assets	**$ _____**
Life Insurance cash value	**$ _____**
Securities	**$ _____**
Other	**$ _____**
Total Assets	**$ _____ (B)**

From what source(s) does the resident plan to pay for services at the Facility (named on Agreement)?

_____

_____

If necessary, would the resident be willing to liquidate his/her assets to pay for services at the facility?

No _____ Yes _____

If the resident's resources become insufficient to meet total expenses while residing at the Facility, are there other persons or organizations that could help pay for services? If yes, please specify.

_____

_____

Are there any safeguards to ensure that your resources are used only for the resident's benefit? If yes, please specify.

_____

_____

During the past five years, has the resident given or transferred any cash, property or other assets (valued at more than 1,000) to any person or organization? If yes, please specify when, to whom, what assets and what their total value was at the time of transfer.

_____

_____

Who will handle the resident's financial affairs while he/she is a resident at the facility (named in agreement)?

Name: _____ Relationship _____

Address: _____ Legal Relationship _____

_____ Telephone _____

In the past seven years has the resident declared bankruptcy or had judgments against them?

No _____ Yes _____

If yes, please specify: _____

_____

Liabilities:

Please list any balance owed by the resident on the items below:

House Loans $ _____ Medical Expenses:

Credit Card $ _____ Doctor $ _____

Automobiles $ _____ Prescription $ _____

Notes $ _____ Hospital $ _____

Total Liabilities $ _____ **(C)**

Estimate of residual assets:

Monthly Income $ _____ (A)

Total Assets $ _____ (B)

Total Liabilities $ _____ (C)

Residual Assets $ _____

Authorization:

I hereby state that to the best of my knowledge, the information on this form is true, accurate and complete. I understand that if any information has been falsely represented, it may be sufficient cause for denying admission or discharging the resident from the center. I authorize the Facility (named in the agreement) to investigate financial and credit records through any investigative or credit agency(s) if it's choice.

Resident: _____ Date: _____

Legal Representative: _____ Date: _____
Legal Guardian, POA, DPOA

Responsible Party/ Agent: _____ Date: _____

Facility Representative: _____ Date: _____

Witness*: _____ Date: _____

Witness *: _____ Date: _____

* Required only if resident is able to sign his/her full name.

December 2018

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Important

Where did you hear about our facility?
Please check all that apply

_____ **Senior Guide**

_____ **Alternatives for Seniors**

_____ **Senior Life Magazine**

_____ **The Catholic Telegraph**

_____ **Cincinnati Magazine**

_____ **Family/ Friends**

_____ **Hospital Social Worker**

_____ **Church Bulletin**

_____ **Internet**

_____ **Other (please indicate)**

_____

_____

_____ **Cincinnati Bell Yellow Pages**

_____ **Yellow Book**

_____ **Older Adults Resource Guide**

_____ **Road to Recovery**

Thank you for taking the time to answer this questionnaire.
We appreciate your input.

December 2018