Saint Margaret Hall

1960 Madison Road
Cincinnati, Ohio 45206

Carmelite Sisters
for the Aged and Infirm

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

Thank you for your interest in St. Margaret Hall. We understand finding the best place for your loved one can be overwhelming, we are here to help throughout the process. If you have questions or would like to set up a tour of our Home, please call the Admission Team.

St. Margaret Hall offers Assisted Living, Short-stay Rehabilitation and Long Term Skilled Nursing.

Assisted Living

Our Assisted Living Community is ideal for seniors who value having trusted help nearby. The daily rate includes assistance with medication administration, bathing, housekeeping as well as three meals per day.

Studio-style rooms range from $170 to $180 per day
Suites range from $215 to $231 per day

There is a $500.00 application fee for our Assisted Living unit applicants. Please make checks payable to St. Margaret Hall.

Skilled Nursing

St. Margaret Hall accepts Medicare, Medicaid and is in network with several managed Medicare and Private Insurers.

Private rooms range from $250.00 to $361.00 depending upon the style of room.

Admission Process

In order to be considered for admission, prospective residents are required to complete an admission application. In addition to the application, a history and physical must be completed by the primary care physician. This document must be completed within five days of admission.

We are here to help you through the Admission process. Please contact the Admission Team at 513-751-5880 with any questions.

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:

____ Home #: ____________
Name Home Address Relationship 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

Risk Assessment of Applicant's Wandering History by Family Member or Responsible Party

St. Margaret Hall

Instructions: Complete and return this form with the Application for Admission. For each question checked YES or NO, explain when indicated.

Resident Evaluation Factors

#	OBSERVATIONS	YES	NO
1.	Does the Applicant exhibit poor decision making skills (i.e. intermittent periods of confusion or disorientation)? **Explain:** ______________________________ ______________________________		
2a.	Does the Applicant walk independently?		
2b.	Does the Applicant move independently with a wheelchair, cane, walker or holding onto furniture?		
3.	Does the Applicant have a vision or hearing impairment? **Explain:** ______________________________ ______________________________		
	If yes—what devices, if any, are used?		
4.	Is the Applicant in agreement with Admission?		
5.	Does the Applicant have a history of leaving his/her home unaccompanied?		
	If Yes, how often has it occurred ____________? When was the last time it occurred ____________? What have you done to prevent the Applicant from leaving his/her home? **Explain:** ______________________________ ______________________________		
6.	Does the Applicant wander aimlessly in his/her home (include time of day)? **Explain:** ______________________________ ______________________________		
7.	What does the Applicant seek when wandering? (i.e. the bathroom, the refrigerator) **Explain:** ______________________________		

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Risk Assessment of Applicant's Wandering History by Family Member or Responsible Party

St. Margaret Hall

#	OBSERVATIONS	YES	NO
	______________________________		
	Have there been any noticeable changes in the Applicant's behavior in the past three months? **Explain:** ______________________________ ______________________________		
8.	Has the Applicant experienced any pain in the past three months? If Yes—What is the location of the pain? ______________ How often does it occur? ______________ How is it relieved? ______________		
9.	Has the Applicant sustained a life altering experience in the past year (i.e. death of a spouse etc.)? **Explain:** ______________________________ ______________________________		
	Comments by Family Member or Responsible Party if Indicated: ______________________________ ______________________________ ______________________________		

Name of Applicant: ______________________________

Signature of Person Completing Form: ______________________________

Relationship to Applicant: ______________________________

Date & Time Completed: ______________________________

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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**

_______ **Cincinnati Bell Yellow Pages**

_______ **Yellow Book**

_______ **Older Adults Resource Guide**

_______ **Road to Recovery**

______ **Family/ Friends**

______ **Hospital Social Worker**

______ **Church Bulletin**

______ **Internet**

______ **Other (please indicate)**

____

____

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

December 2018