MORROW HOME A Well-Designed Senior Living Community

Nursing Home & Rehab
331 S. Water St.

Parkview Apartments
315 S. Spring St.

Homestead Apartments
331 S. Water St.

MaryCrest Apartments
401 S. Water St.

BridgePath Advanced Assisted Living * Memory Care
503 S. Water St.

Sparta, WI 54656 www.morrowhome.org 608-269-3168

Adult Living Services, Independent & Assisted Living
Housing Office 608-366-6293 Fax 608-269-1547

Nursing Home & Rehabilitation
Social Workers Office 608-366-6241 Fax 608-269-1771

ADULT LIVING SERVICES APPLICATION for Independent, Assisted, Advanced Assisted, Memory Care

Morrow Home Community requires an application to be on file prior to any potential applicant age 55 and older being considered for any housing in any setting and is subject to approval. The accepted application shall remain on file for a period of 1 (one) year from date of submission. If the written application remains on file over one year due to continued contact, the potential applicant is required to update the financial information in order to keep the application in acceptance status.

This application will be part of the Resident Service Agreement and **must** be completed in its entirety. Morrow Home and its extensions affords equal treatment and access to its facilities and services for all persons without unlawful discrimination due to race, color, religion, sex, age, national origin, ancestry, or disability. **All information is held in confidence.**

If application is for a married couple-please fill out a separate application for each partner.

Full Name: ____Nickname: ____________Date:______
First Middle Last

Current Address:____

____
City County State Zip Code

Telephone#:________________ Cell#:_______________

Occupation prior to retirement:________________E-mail Address: ____________________________

Date of Birth: Month ______Day _______Year ________Birthplace ________________________

Marital Status: Never Married______ Married_____ Widowed _____ Separated ____ Divorced______

Spouse's Full Name: ____

Religion:
____

Church Affiliation: ____

Pastor: ____

Ethnicity: o Hispanic/Latino o Not Hispanic/Latino o Resident declines o Other_______________

Race: o American Indian/Alaskan Native o Asian o Black/African American o White
o Unknown o Hawaiian/Other Pacific Islander o Other o Resident declines

1– 1st Contact Responsible Party Self? Yes_____ No_____ If no: ________________________

Name_____________________________ Relationship _________

Address ____

*Phone #s Home*_____________ *Mobile*_______________ *Work*_________________

Circle Primary Phone Contact preference

Email address____

Preferred method of contact:

Email_____ O.K to call_____ Do not call_____ Include in mailings? Yes_____ No_____

2– POAH Power of Attorney Designated for Healthcare/Medical decisions (may be same as 1st contact)

Responsible Party Self? Yes_____ No_____ POAH Activated? Yes_____ If yes, date?——No_____

Name_____________________________ Relationship _________

Address ____

*Phone #s Home*_____________ *Mobile*_______________ *Work*_________________

Circle Primary Phone Contact preference

Email address____

Preferred method of contact:

Email_____ O.K to call_____ Do not call_____ Include in mailings? Yes_____ No_____

3– POAF Power of Attorney Designated for Financial decisions (May be same as 1st or 2nd contact)

Responsible Party Self? Yes_____ No_____ If No, POAF Designee:

Name_____________________________ Relationship _________

Address ____

*Phone #s Home*_____________ *Mobile*_______________ *Work*_________________

Circle Primary Phone Contact preference

Email address____

Preferred method of contact:

Email_____ O.K to call_____ Do not call_____ Include in mailings? Yes_____ No_____

4– If above contacts are unavailable:

Name_____________________________ Relationship _________

Address ____

*Phone #s Home*_____________ *Mobile*_______________ *Work*_________________

Circle Primary Phone Contact preference

Email address____

Preferred method of contact:

Email_____ O.K to call_____ Do not call_____ Include in mailings? Yes_____ No_____

PLEASE INCLUDE COPIES OF POAH. IF POAH HAS BEEN ACTIVATED BY THE SIGNING OF 2 DOCTORS, INCLUDE COPY OF ACTIVATION. PLEASE INCLUDE COPIES OF POAF ALSO. THANK YOU.

_____I Give consent for the release of medical or other information to the persons listed as my emergency contacts.

_____I do not want information shared with my emergency contacts unless I request this.

_____In addition to my emergency contacts, I give my permission to have medical or other information shared with the following individuals:____

INSURANCE INFORMATION

Social Security #: ________________________

Long Term Care Insurance? ____Yes _____No

Name:_________________________________ Policy#:________________________________

Address:_______________________________ Benefit Period:__________________________(lifetime or years)

Phone #:______________________________ Assisted Living Daily Benefit_________ SNFDaily Benefit___________

Medicare A #:___________________________ Medicare B #: __________________________

Medicaid#:________________________________

other Insurance-Name(s) and Policy #(s): ____

Note –** **_please include ALL insurance information_. Bring in cards when submitting application so copies can be made of both front and back of cards. This will be kept confidential.

FINANCIAL DATA (The information supplied is kept strictly confidential.)

Are you a member of a Family Care funding program?

_____Yes* _____No *Name of Social Worker: ________________________ Name of Program:_____________________________

ASSETS:

	AMOUNT	TOTALS
Checking Balance	$______________	
Savings Accounts and CD's	$______________	
Stocks and Bonds (Approximate current value)	$______________	
Real Estate Owned	$______________	
Description: o Home o Farmland o Rental Property		
Funds Held In Burial Trust	$______________	
TOTAL ASSETS:		**$________________**

LIABILITIES:

Home Mortgage (Remaining Balance)	$______________	
Loan Payments (Remaining Balance)	$______________	
Other Liabilities-please describe	$______________	
TOTAL LIABILITIES:		**$_________________**

NET ASSETS – BALANCE $______________

MONTHLY INCOME:

Social Security	$_______________
Private/Government Pension	$_______________
Investment Income	$_______________
Trust Income	$_______________
Other Income	$_______________
TOTAL MONTHLY INCOME	**$______________**

The Morrow Home Community strives to inform the public in the best ways possible of its resources. Please take a moment to check any of the following:

I heard about the Morrow Home by: ____friend ____relative ____own research

____website ____Morrow Home Messenger ____poster ____other

MILITARY INVOLVEMENT

Veteran ______ Yes ________ No Spouse of Veteran? _______Yes ________No

Branch of Military Served In ________________________________

Veteran of a Foreign War where you served active duty during war time? _______Yes _______No

Please specify ____

Contact Charles Weaver, Veteran's Service Officer for information on possible benefits 608-269-8726 charles.weaver@co.monroe.wi.us

GENERAL PREFERENCES

Attending Physician: ____

Phone: ____________________ Hospital: ____

Alternate Physician: _______________________ Phone: __________________________________

Pharmacist: _____________________________________

Dentist: _______________________ Funeral Home: ________________________________

Any physical, medical, memory issues, or personal concerns\needs of which we should be aware:

____

____

____

Any prior physical therapy _____ Yes _____ No If yes, where _________________

Hospice Company Name: ______________________________Phone #: ________________

Address: ____Policy #: ______________

I ____________________(name) make this application for residency in the Morrow Home Community of my own free will and accord. I declare the answers to the foregoing questions to be true, full, and complete to the best of my knowledge. Any material misstatement in the information or subsequent transfer of assets empowers Morrow Home to void the application approval and/or resident agreement. I understand the Morrow Home may verify statements given in this application.

Date: _____________________ Signature of Resident: ____

Person Assisting with completion of application: ____

Return Adult Living Services Application to:	401 S. Water Street, Sparta, WI 54656 *Attn: Housing Coordinator* Fax: 608-269-1547 Email: jkoehler@morrowhome.org
Return Nursing Home Application to:	331 S. Water Street, Sparta WI 54656 *Attn: Social Services* Fax: 608-269-1771 Email: lweibel@morrowhome.org

Disclaimer: Employees, former employees, Board members, former Board members, current and former residents have priority of admission to Morrow Home Adult Living Services over any other individual in the same criteria. This is a courtesy/amenity given to individuals who have contributed their service, and entrusted their care to Morrow Home.

MORROW MEMORIAL HOME
CONSENT TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will, respect the privacy of your health information.

Resident Name:____________________________________**Date of Birth:**________________________

1. Permission to Use and Disclose Your Health Information.

By signing this consent, you authorize us to use and/or disclose your health information for treatment, payment, or health care operations. You have the right not to sign this consent. Howerver, if you refuse to sign this consent, we have the right to refuse to treat you.

2. Your Rights With Respect to This Consent.

a. Right to Review Notice of Privacy Practices.

We have provided you, along with this consent form, a copy of our Notice of Privacy Practices ("Notice") which details how we may use and disclose your health information. You have the right to review this Notice before signing this consent. We may amend the Notice from time to time. You may obtain a copy of our Notice, including any revisions we have made by contacting Kari Russell, Director of Adult Living Services; 401 South Water Street, Sparta, Wisconsin 54656 (608) 366-6288.

b. Right to Request Restrictions on Use/Disclosure.

You have the right to request that we restrict how we use and/or disclose your health information for the purpose of providing treatment, obtaining payment for our services, and/or conducting health care operations. Such requests must be made in writing. Please note that we are not required to agree to any restrictions you may request. If, however, we agree to a restriction you have request, we must restrict our use and/or disclosure of your health information in the manner described in your request. To obtain a restriction request form, please contact Kari Russell, Director of Adult Living Services; 401 South Water Street, Sparta, Wisconsin 54656 (608) 366-6288.

c. Right to Revoke Consent.

You have the right to revoke this consent at anytime. Your revocation of this consent must be in writing. If you wish to revoke this consent, please contact Kari Russell, Director of Adult Living Services; 401 South Water Street, Sparta, Wisconsin 54656 (608) 366-6288 to obtain a revocation form. Note that your revocation of this consent will not be effective for disclosures we have already made in reliance on your prior consent. We also have the right to refuse to provide further treatment if you revoke this consent.

d. Right to Receive a Copy of This Consent Form.

You have a right to receive a copy of this consent form after you sign it.

3. Effective Period.

This consent is effective on the date of signing and shall remain in effect indefinitely, unless you revoke it earlier in writing.

I hereby authorize *Morrow Memorial Home, Sparta, Wisconsin* to use and/or disclose my my health information for treatment, payment, or health care operations.

Resident Signature:____**Date:**____________________

BridgePath Resident:

Resident is unable to sign because:____
____

Name of Personal Representative:____

Relationship to Resident:____

Authority of Personal Representative (health care power of attorney, guardian, other statutory authorization):
____

Adress:____**Phone Number:**____________________________

Signature of Personal Representative:____**Date:**__________________