

# 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](http://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

**PLEASE INCLUDE COPIES OF POAH, POAF, Advanced Directives, if applicable. IF POAH HAS BEEN ACTIVATED BY THE SIGNING OF 2 DOCTORS, INCLUDE COPY OF ACTIVATION. THANK YOU.**

**1- 1st Contact in case of emergencies**  
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 \_\_\_\_\_

\_\_\_\_\_ 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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?	
<input type="checkbox"/> Yes* <input type="checkbox"/> 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: <input type="checkbox"/> Home <input type="checkbox"/> Farmland <input type="checkbox"/> Rental Property		
Funds Held In Burial Trust	\$ _____	
<b>TOTAL ASSETS:</b>		<b>\$ _____</b>

LIABILITIES:	AMOUNT	TOTALS
Home Mortgage (Remaining Balance)	\$ _____	
Loan Payments (Remaining Balance)	\$ _____	
Other Liabilities-please describe	\$ _____	
<b>TOTAL LIABILITIES:</b>		<b>\$ _____</b>

<b>NET ASSETS – BALANCE</b>	<b>\$ _____</b>
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MONTHLY INCOME:	AMOUNT	TOTALS
Social Security	\$ _____	
Private/Government Pension	\$ _____	
Investment Income	\$ _____	
Trust Income	\$ _____	
Other Income	\$ _____	
<b>TOTAL MONTHLY INCOME</b>		<b>\$ _____</b>

<p><b>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:</b></p> <p>I heard about the Morrow Home by: <input type="checkbox"/> friend <input type="checkbox"/> relative <input type="checkbox"/> own research  <input type="checkbox"/> website <input type="checkbox"/> Morrow Home Messenger <input type="checkbox"/> poster <input type="checkbox"/> other</p>
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**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: <i>Housing Coordinator</i> Fax: 608-269-1547 Email: jkoehler@morrowhome.org
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**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. However, 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): \_\_\_\_\_