Move-In Procedure

www.HopedaleSeniorLiving.com
309.449.6790
221 SW Railroad St - Hopedale, IL 61747

Move-In Procedure

Below are the Move-In requirements for entry into Hopedale commons.

1. Completion of Hopedale Commons Admission Booklet
2. Completion of Physical Therapy Screening prior to admission.
   This appointment as well as Physician appointment should be setup by the resident's family.
   Please contact the Director or Secretary for numbers to call.
   After appointments are made, please contact our office with the information.
3. Completion of Move-In physical completed by a physician from HMC Medical Arts Office.
4. Approval of Move-In Physical and Physical Therapy Evaluation. (Resident(s) cannot move into an apartment until both examinations are completed.)
5. Move-in application completed and turned into into Assistant manager of either Commons East or Commons West.
6. Reserve apartment and deposit if applicable
7. Set date for moving into apartment
8. Sign Contract. Must be signed before moving into apartment
9. Pay first month's rent and security deposit. Note: Financial assistance (reduced rent) is available for those residents who qualify. Please inquire of the Director for an application.
10. Please provide copies of insurance cards, POA or Guardianship papers and living will as part of a requirement for admission.

Residents of Hopedale commons must meet the following requirements:

1. Able to feed and dress themselves with some assistance
2. Able to bathe with some assistance
3. Able to take medications with medication reminde
4. Able to ambulate on their own with use of wheelchair, walker, or cane
5. Must be continent of bowel & bladder. May use incontinent briefs, but must be managed by the resident

Hopedale Commons Assisted Living/Independent Living Move-In Application:

Date of Pre Move-In Physical_____ Physician's Name_____Appointment Time_____

Date of Physical Therapy Eval_____Appointment Time_____Projected Move-In Date_____

Name_____Date of Birth_____Age_____Birthplace_____

S.S#_____Medicare#_____Marital Status___M___W___D____

Nearest Relative_____Relationship_____(Relative's Spouse's Name)_____

Address_____

Power of Attorney Name_____Ph#_____(POA's Spouse's Name)_____

Address_____

Religion_____Clergy_____Ph#_____Address_____

ANSWER ALL QUESTIONS REGARDING RESIDENT:

What is the current condition requiring the need for assisted or independent living:?

_____

_____

Is resident able to speak and verbalize needs? Y or N In English? Y or N

If no, how does resident communicate or use what language? _____

Has resident had a history of falls? Y or N Date of last fall (if applicable) _____

Does resident have a Urostomy or Colostomy? Y or N Explain_____

Does resident use Oxygen? Y or N If yes, what liters per minute? _____L/min

Has resident recently been treated for MRSA, Clostridium Dificile or any other contagious infection or disease? Y or N

If yes, when and where_____

_____

When was resident's last hospital stay?_____

Application

Does resident have a history of dizziness, stroke, congestive heart failure, or heart attack?

Please Explain:_____

Is resident continent of urine? Bowel? Please Explain: _____

Does resident use incontinent briefs I.E. Depends, Attends, Etc. Y or N _____

Does resident wear compression hose ("Juzo")? Y or N _____

Does resident have issue of depression or mental instability? Y or N Explain:_____

_____

Education

Grammar_____School_____High School_____College_____Advance Degree_____

Military: Y or N _____

Is applicant a Registered Voter? Y or N If no, would he/she like to register? Y or N N/A

Does resident own a vehicle that will be brought to commons? Y or N

If yes, please provide model, make, and license plate number _____

Do you wish to rent a carport space? Y or N

Do you have a valid Driver's License? Y or N

Please provide a copy of your Driver's License.

Signature of resident: _____ Date_____

OR:

Signature of Patient/Resident Representative: _____ Date_____
Ph#_____

Signature of Patient/Resident Representative: _____ Date_____
Ph#_____

Responsible party address: _____
Email:_____

FOR OFFICE USE:

Admit Date: _____Apt.#_____Rate:_____Auth Initials: _____

Dietary Needs

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Hopedale Commons Assisted Living/Independent Living Dietary Needs:

Difficulty Swallowing Yes___ No___ Explian_____

Recent Weight Change Yes___No___ Special Equipment for Eating Yes____No____Explain_____

Dietary Restrictions? Yes____No____ Explain_____

Food Allergies Yes___No___Explain_____ Snacks between meals Yes____No___

Food Likes_____ Dislikes_____

Communication

Vision: Left Eye: Normal___Impaired___Blind____ Right Eye: Normal___Impaired___Blind___

Does Applicant wear glasses? Yes___No___ Applicant use communication boards/cards Yes____No____

Does the applicant wear a hearing aid(or other adaptive device)? Yes___No__ Needs assist with Yes____No_____

Verbal Communication: No problem/clear speech_____Difficult to understand_____Uses gestures_____

Speech is slurred_____ profane speech_____ Other_____

Mental Awareness

Mental Awareness: Alert_____ Coherent Alert/mild disorientation_____ Confused often_____

Orientation: Self_____ Time_____ Place_____ Person_____

Short Term Memory: Good_____ Fair/Some Recollection_____ Impaired_____ Highly Impaired_____

Long Term Memory: Good_____ Fair/Some Recollection_____ Impaired_____ Highly Impaired_____

Attention Span: Good_____Fair_____Easily Distracted_____Highly Impaired_____

Ability to make choices: Good_____ Fair_____ Easily Distracted_____ Highly Impared_____

Ability to read: Yes_____ Large Print_____ Limited Ability_____ No_____

Ability to speak English: Good_____ Fair_____ Poor_____

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Hopedale Commons Assisted Living/Independent Living Dietary Needs:

Phychosocial Well-being

Wanders_____ Disruptive_____ Verbally Loud_____ Angry/irritable/anxious/nervous_____

Social Concern:_____ Explain: _____

Sadness over lost roles: _____ Prefers to be alone _____ Prefers 1:1_____Prefers to stay in room_____

Naps? ___AM ___PM_____ Spends time with family_____ Enjoys visiting _____ Enjoys being outside_____

I am most happy when? _____

My favorite time of the year is: _____**Because?** _____

PLEASE INDICATE APPLICANTS USUAL DAILY ROUTINE WITHIN THE LAST 6 MONTHS AS MUCH AS YOU ARE AWARE

Time awakens/goes to bed _____

Eating Habits (snacks, meals skipped, etc.)_____

Sleeping Habits (interrupted, sleeps most of the night, sleeps in a chair, naps, etc.)_____

Any other information about daily routine that may be helpful_____

The Hopedale Commons
Premier Independent & Assisted Living

Interest Survey

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Hopedale Commons Assisted/Independent Living Activity Interest Survey

Recreation & Leisure	Current	Past	Maybe	No	Recreation & Leisure	Current	Past	Maybe	No
Cards/Other games					Cooking/Baking				
Exercise/Walking/Sports					Movies				
Music					Social Events/Parties				
Reading/Writing					Poetry				
Spiritual/Religious					Bingo				
Being Outdoors					Clubs/Organizations				
Television/Radio					Travel				
Gardening/Planting					Pet Interaction				
Talking or Reminiscing					Intergenerational Programs				
Helping/Assisting others					Puzzles				
Sewing/Knitting/quilting					Collecting (i.e. coins, stamps)				
Crafts/Arts					Other:				
Other:									

Recreational & Leisure interest comments:

_____

_____

_____

How has illness/poor health changed the patient's leisure interests?

_____

_____

_____

Strengths & Abilities	1	2	3	4	Strengths &Abilities	1	2	3	4
Able to see/hear					Finds strength in spiritual/faith				
Able to ambulate/propel					Desires new leisure skills				
Able to Socialize					Strives to regain/retain independence				
Strong Identification with Roles					Offers suggestions/ideas				
Develops coping skills/changes					Special Interest/talent				
Leadership Abilities					Establishes his/her own goals				
Desires to help others					Self-initiates				
Aware of environment					Other:				

OTHER:

_____

_____

Information provided by: _____ **Date:** _____

Hopedale Commons Financial Information

Is the resident aware that Hopedale Commons is a private pay facility that does not participate in Medicare, Medicaid or public aid programs? ☐ Yes ☐ No

Will the resident be paying for their care out of private personal funds? ☐ Yes ☐ No

Will a family member be responsible making sure monthly rent will be paid? ☐ Yes ☐ No

If yes, what is name of the family member who will be responsible. _____

FINANCIAL INFORMATION: This is very confidential and only seen by Director of Commons and C.O.O.

FUND ACCOUNT:	NAME OF BANK/SOURCE	APPROXIMATE VALUE (PER DAY / MONTH / YR, TTL)
Checking Account		
Savings		
CD's / Securities		
Real Estate Value		
Other (rent, SS, pension, Long Term Care Insurance)		

Signature of resident _____ Date_____

Or - Signature of resident representative:

_____Date_____ Phone Number:_____

POA of Healthcare / Finance (circle)

_____Date_____ Phone Number:_____

POA of Healthcare / Finance (circle)

Responsible Party Address: _____

_____

Email:_____

FOR OFFICE USE:

Admit Date: _____ Apt.# _____ Rate:_____Auth

Initals_____Please seal and return in enclosed envelope.

The Hopedale Commons
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Services Not Provided

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Services not provided by Hopedale Commons

The following is a list of services that the staff at Hopedale Commons CAN NOT provide:

1. Daily baths, but can provide baths one to two times weekly.
2. Catheter care
3. Colostomy Care
4. Wound Care
5. Post-surgery assistance
   (this includes assistance each time resident must use bathroom or transfer from wheelchair).
6. Assistance each time a resident must get dressed or undressed
7. Assistance each time a resident comes to or from the dining room

Resident and/or family members are responsible for the following items:

1. Laundry basket with resident's name on it
2. Bedspread or comforter for the bed and pillows
3. Toiletries: soap, toothpaste, toothbrush, comb, shaving items, etc.
4. Bath rug with resident's name on it
5. Special light bulbs. Batteries for radio, clock, hearing aids, flashlights, etc.

PLEASE DO NOT BRING ELECTRICAL APPLIANCES SUCH AS TOASTERS, TOASTER OVENS, ELECTRIC COFFEE MAKERS, IRONS, ELECTRIC HEATING PADS, CURLING IRONS, ETC. WITHOUT APPROVAL OF THE DIRECTOR. THESE ITEMS MUST BE CHECKED BY THE MAINTENANCE DEPARTMENT BEFORE THEY ARE ALLOWED IN A RESIDENT'S APARTMENT.

Some small personal items may be purchased at our gift shop on site or on our monthly trip to Wal-Mart.

Medication Service

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Medication Services:

We at the Commons are asking residents and or family members who are their guarantors if you wish to retain the services of a nurse to fill the resident's medication tray each week or if you wish to provide the service yourself.

If you do not wish to contract a nurse for this medication service, you may make your own arrangements and discuss them with the Administrator.

Please respond below:

___Yes, I wish to contract services of a nurse to fill the medication tray for _____
*This service is <u>included</u> in Assisted Living. For Independent living, there is a $30.00 monthly charge.

___No, I will make other arrangements to provide medication services for_____

Resident Signature:_____
POA Signature: _____
Date: _____

The Hopedale Commons
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New Residents

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Hopedale Commons Assisted Living/Independent Living:

We, at the Commons, are asking residents and/or family members who are their guarantors if you wish to have Hopedale Pharmacy fill your family member's prescriptions.
Yes, I wish to use Hopedale Pharmacy to fill_____ Prescriptions.

No, I wish to use _____ /// _____
to fill _____Prescriptions.

We encourage our residents to be physically fit. For more information please contact the Membership Coordinator of the Hopedale Wellness Center at 309-449-4500.

ITEMS TO BE SUPPLIED BY NEW RESIDENTS ARE AS FOLLOWS:
Bedspread and Pillows
Laundry basket (with name of resident)
Bath Rug (Non-Skid backing)
Flashlight and batteries
Personal grooming items
Clock
Additional phone
Special light bulbs (if needed)
$10.00 for nameplate

ALL CLOTHING MUST BE MARKED WITH A RESIDENT'S NAME WITH PERMANENT MARKER

REMINDER

Please remember to bring copies of current Medicare, Social Security Card, Living Will, Secondary insurance cards, Prescription cards, Power of Attorney of Finance, if another person other than resident will be paying bills.

Please return all above information to Director of Commons office in order to accurately expedite the admission process.

Thank you for your prompt and thoughtful attention to these questions. This information will greatly assist us in providing the best care possible for your family member as they become a member of our community in Hopedale Commons.

The Hopedale Commons
Premier Independent & Assisted Living

Records Release

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PATIENT'S CONSENT TO RELEASE PROTECTED HEALTH INFORMATION (PHI)—ADULTS
Medical Records Department (309) 449-4288
ADULT PATIENT

Patient's Name (please print) _____ Date of Birth_____
Patient's Complete Address_____
The undersigned hereby authorizes use or disclosure of Protected Health Information (PHI) about the patient named above and described below.

1. Hopedale Medical Complex (HMC), including Hopedale Hospital, Hopedale Nursing Home, Medical Arts Physicians, Hopedale Pharmacy, Hopedale Wellness Center, Hopedale Commons and all its entities/employees are authorized to use or disclose Protected Health Information (PHI) about the patient. "PHI" includes individually identifiable information and medical records relating to patient's health, healthcare provider, billing, insurance and demographic information.
2. The following person (or class of persons) is authorized to receive disclosure of (PHI) about the patient. His/her name, address, and phone:
   (a) _____ (b)_____
   _____ _____
   _____ _____
3. The specific medical records/PHI that should be disclosed are (please give dates of service if possible):
   (a) ALL PHI(initial here) _____
   (b) Only the following PHI_____

Note: For hospital in-patients, HMC may release the patient's general condition (Good, Fair, etc.) to all persons inquiring (including family) unless you initial here: _____DO NOT DISCLOSE PATIENT CONDITION

4. The undersigned understands that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by federal privacy regulations.
5. The undersigned may revoke this authorization by notifying Hopedale Medical Complex Medical Records Department or the Chief Operating Officer. However, the undersigned understands that action already taken in reliance on this authorization cannot be reversed, and a revocation will not affect those actions. The undersigned understands that HMC may not condition its treatment of the patient on whether or not this authorization is signed.
6. This authorization expires 6 years from today's date, and will remain valid even if Patient becomes incapacitated following signature. If patient wants authorization to expire sooner or upon some future event, indicate here: _____

Fees for copies: Federal and state laws permit a fee to be charged for the copying of patient records. You may be required to pre-pay for the copies; if not, then your copies will be mailed along with an invoice. You agree to pay said invoice within 30 days.

THIS FORM MUST BE COMPLETED BEFORE SIGNING:

_____	_____	_____
Signature of Patient	Date of Signature	Date of Birth or S.S.#

OR, if applicable-

_____	_____	_____
Signature of Guardian or Personal Representative	Date of Signature	Description of Authority (POA, Guardian, Executor)

*A COPY OF THIS COMPLETED, SIGNED AND DATED FORM MUST BE GIVEN TO THE INDIVIDUAL OR OTHER SIGNATOR

POA/Family Information

We at Hopedale Commons would like to offer the following suggestions for residents of Hopedale Commons.

1. Always leave an emergency number if you are going to be out of town. We may need to contact you or someone you designate if there is an emergency.
2. If you have not already done so, please discuss Living Will with your family member
3. Please visit your family member on a regular basis. Weekly would be great, especially weekends when most of our staff and activities are at a minimum and the days seem longer. Residents enjoy car trips and going out to eat.
4. Please coordinate any appointment you make for your loved one with our nurse, transport person, or Director. Many times if we know about the appointments we can have the resident ready, meds ready, etc.
5. Please use the "Sign Out" book located on the shelf near the Visitor's Book.
6. Also, if you will be returning after 8:30p.m., there is a doorbell to use after hours or a 24-hour phone number to call if the door is locked. The phone number is 309-449-6790.
7. Finally, if your famiy member has any complaints or problems, please advise the Director. If it is an urgent concern please call Director at 309-449-4939. If the concern is non emergent, please see the Director on the next business day.

Thank you for your cooperation and assistance in giving your family member the most comfortable and personal care possible here at Hopedale Commons.

Policy for notification of Resident's Family

It is the policy of Hopedale Commons Assisted and Independent Living to notify designated family members and/or POA when a resident has an incident or is taken to the Emergency Room for any reason.

It will be the responsibility of the Director of the Commons to contact the above named or designate a Commons staff member to make the necessary phone call.

This call will only inform family or POA that a resident has had an incident or is in the Emergency Room. All other medical questions will be referred to attending Physician and nursing staff.

Furthermore, if a resident's Emergency Room visit becomes an overnight stay in the hospital it will be the Director's responsibility or designated Commons staff members to inform family of the upgrade in care.

If there is a significant change in a resident's condition or if it is necessary to terminate the residency at Hopedale Commons Assisted and Independent Living, it will be the responsibility of the Director of Commons to contact the family and POA to setup an appointment to discuss the above-mentioned issues.