St. Patrick's Residence

Nursing and Rehabilitation
Served by the Carmelite Sisters for the Aged and Infirm
"The Difference is Love" SM

Thank you for your interest in considering St. Patrick's Residence as a long-term care provider. Below you will find a checklist to assist you in the process of applying to our facility. Once all documents are completed in their entirety, a representative from our admissions team will contact you to discuss your application in more detail.

Admissions Checklist

All items must be completed in their entirety for consideration.

- ☐ Admission Application
- ☐ Health History and Physical Form or Clinical Referral, if coming from a healthcare facility
- ☐ Additional Financial Information For Long-Term Care Applicants (State IL Form 3654)
- ☐ Current Copies of Financial Statements (See Admission Application)

All applications will remain on file for one calendar year from date of completion.

1400 Brookdale Road • Naperville, Illinois 60563-2126 • (630) 416-6565 • Fax: (630) 416-8755

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Date: ____/____/____

Admission Application

Personal Information
Name: (First) (Middle) (Last)

Preferred Name:	Race:
Gender:	Religion:
Date of Birth (Mo., Day, Year): Age:	Marital Status: If Married, Name of Spouse:
	Language:
Telephone Number: ( ) Address: City: State: Zipcode: County:	Previous Occupation: Mother's Maiden Name: Military Service:
Who referred you to St. Patrick's Residence?	

Insurance Information	
Social Security Number:	Medicaid Recipient Number:
Medicare Number:	Medicare Part D: ❑ Yes ❑ No Medicare Part D Number:
Life Insurance Company Name(s):	Policy Number(s):
Amount(s):	Premium(s):
Medical Insurance Company (other than Medicare):	ID Number: Group Number:

Medical Status

Physician: Address: Date of Last Exam:

Place of Last Skilled Nursing Facility: Location: Date:

Place of Last Hospital Admission: Location: Date:
Reason for Admission:

Previous Psychiatric Care: ❑ yes ❑ no Location: Date:
Reason for Psychiatric Care:

Substance Abuse Problems: ❑ yes ❑ no (If yes, please explain)

Date of Last Pneumonvax? Date of Last Flu Shot:

Allergies:

Responsible Family Members or Friends
(In case of emergency, these individuals will be contacted in the order they are listed.)

Power of Attorney for Healthcare:

Name: Home Phone:
Address: Work Phone:
City, State, Zipcode: Cell Phone:
Relationship: E-mail:

Power of Attorney for Finances (if different from above):

Name: Home Phone:
Address: Work Phone:
City, State, Zipcode: Cell Phone:
Relationship: E-mail:

Additional Contact:

Name: Home Phone:
Address: Work Phone:
City, State, Zipcode: Cell Phone:
Relationship: E-mail:

Additional Contact:

Name: Home Phone:
Address: Work Phone:
City, State, Zipcode: Cell Phone:
Relationship: E-mail:

Burial Arrangements

Funeral Home: Address:
City, State, Zipcode:
Telephone Number:

Confidential
(The following is for St. Patrick's Use Only and not for Public Knowledge)

Financial Resources

Please List:

Monthly Income Source	Amount
Social Security	_____
Pension	_____
Annuities	_____
Other:	_____

Please List:

Checking Account (If joint account, list all parties names)	Bank Name	Amount

Please List:

Savings Account (If joint account, list all parties names)	Bank Name	Amount

Please List:

Stocks, Bonds and Investments (If joint account, list all parties names)	Company	Current Value

Please List:

Real Estate (If joint account, list all parties names)	Location	Current Value

Is there a mortgage on the property? ❑ Yes ❑ No
If so, what is the current amount of the mortgage: _____

Personal Property
(List all assets of Resident, not listed above)

**** Please attach copies of most recent account statements. ****

Power of Attorney
(In the event that a resident, for any reason, becomes incapacitated)

Guardianship or Power of Attorney: Relationship:

Address: ( )
(Street) (City, State, Zipcode) Telephone Number

Signature of Person who will assume financial responsibility for paying the bills and completing Medicaid application, if and when necessary:

Print Name: Signature:

Please Read and Sign Below

I/We the undersigned hereby certify that the answers to the foregoing questions are true, correct and complete, that I/We have not knowingly or intentionally withheld any facts or circumstances which would, if disclosed, unfavorably affect the prospective Resident's application for admission. I/We hereby authorize a full investigation of any statement contained in this application by (Facility) or its agents. I/We understand that misrepresentation or omission of facts or information requested will be considered sufficient cause for denial of Resident's application for admission, or for immediate transfer or discharge of Resident from Facility.

Signature of Applicant: Signature of Responsible Party and/or Guardian:

Signature of Witness: Date:

** SEE ATTACHED ADDENDUM **

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Addendum to Admission Application

Income and Personal Resource Statement – Agreement and Undertaking

I hereby represent to Facility that, under the terms of a Power of Attorney for Property executed pursuant to the Illinois Power of Attorney Act (a copy of which I will deliver to Facility), I have access to _____ (Name of Applicant) income and resources, which are available to pay for care Facility provides, and I have authority to execute this Agreement and Undertaking. Accordingly, I agree as follows:

1. I understand that, under the terms of the Agreement to which this Addendum is attached, I am the Person who will assume financial responsibility for paying my Resident's bills and, when necessary, completing an application for Medicaid for him/her.
2. I affirm that the information I have provided Facility in the Admission Applicaton is true and correct to the best of my knowledge.
3. I shall pay such income and resources, or funds I receive from Resident, to Facility when and to the extent needed for the payment for Resident's care at Facility;
4. I shall not use such income and resources for any purposes other than the foregoing or for Resident's benefit, during Resident's stay at Facility; and
5. I shall assign such income and resources to Facility at Facility's request to the extent necessary to pay for Resident's care at Facility.

This Agreement and Undertaking is limited to Resident's income and resources to which I have access and does not bind me to make any payment for Resident from my personal assets.

Signature of Resident or
Responsible Party: _____ Date:____/____/____

Print Name: _____

Relationship to Resident: _____

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Date:_____

Code Status:
Allergies:

Health History and Physical Form

(To be completed by Physician)

(Please Print)

Physician:

Address: ( )

(Street) (City, State, Zip Code) Telephone Number

RESIDENT INFORMATION:

Name : Age: Place of Birth:

Chief Complaints:

Previous Medical History:

Surgical (list all previous operations):

Physical Examination

General Condition:
- ❑ ambulatory
- ❑ wheelchair
- ❑ bedridden

Skin: Muscle Tone: Nourishment: Height: Weight:

Eyes: Right: Left: Vision:

Ears: Right: Left: Hearing:

Nose and Throat: Teeth: Tongue: Speech:

Breasts:

Lungs:

Heart: Impulse: Interspace: cm m.s.l: Rhythm: Rate:

Sounds: Murmurs:

Pulse Rate: Quality: Arteries:

Blood Pressure:

Abdomen: Liver: Spleen:

Genitalia: Incontinence: Bladder: Bowels:

Rectal: Lymph Nodes:

Extremities: (edema, ulcers, varicosity, etc.)

Reflexes: Patella Achilles Ankle Clonus Babinski

Physical Examination (continued)

Date of Last Pneumonvax? Date of Last Flu Shot:

Mental Deterioration: ❑ None ❑ Slight ❑ Marked
(Describe in Detail)

Diagnosis:

Progress Notes

Is there any disabling condition present, describe in detail:

Is the patient free from any communicable diseases? ❑ yes ❑ no If no, please provide details:

Is nursing care or supervision required? ❑ yes ❑ no If yes, please provide details:

Is special medication required? ❑ yes ❑ no If yes, please provide dosage:

Is a special diet required? ❑ yes ❑ no If yes, please provide details:

Restorative Goals:

May Patient Participate in Activities, as tolerated? ❑ yes ❑ no
If not, please provide details:

_____M.D.
(Signature)

❑ I will remain as resident's attending physician
❑ I will not remain as resident's attending physician

State of Illinois
Department of Healthcare and Family Services
Department of Human Services

ADDITIONAL FINANCIAL INFORMATION FOR LONG TERM CARE APPLICANTS

Questions on this form pertain to resources that you and your spouse, including someone else on behalf of you or your spouse, have transferred in the past 60 months.
Transferring a resource means:

- **Selling a resource**
- **Giving a resource away**
- **Giving part of a resource away**
- **Changing the ownership of a resource to someone else**
- **Reducing ownership of a resource, such as adding another owner**

If you are:
Mark the box that applies

☐ A new applicant applying for medical benefits and you need help with Nursing Home or Supportive Living Program services or Department on Aging Home and Community Based Services. Attach completed form to your paper application or upload with your electronic application when you file through abe.illinois.gov.

☐ A person who has received medical benefits from the State of Illinois for *less than 6 months* immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services. Send completed form by the due date to the appropriate DHS office.

☐ A person who has received medical benefits from the State of Illinois for *6 months or longer* immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services and you answer YES to One or More of the questions 1-13 on this form:

- complete this form; and
- send completed form by the due date to the appropriate DHS office.

If you are:

☐ A person who has received medical benefits from the State of Illinois for *6 months or longer* immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services and your answer to Every question 1-13 on this form is NO:

- **You are not required to complete; or**
- **return this form by the due date**

Any false statements or concealment of material fact may be cause for prosecution or other appropriate legal action. Failure to cooperate or provide documentation or information may result in the denial of assistance.

Notice will be sent to all persons approved to receive assistance with nursing home and supportive living program services and Department on Aging Home and Community Based Services.

Name of Person Requesting Assistance

Last Name _____ First Name _____ Middle Initial _____

SS# _____ DOB _____

Name of nursing home or
supported living facility (if applicable) _____

Date of Admission _____

Instructions:

- Attach additional pages if more room is needed to completely answer any question(s)
- Provide documentation with this form to support information you have told us about the resources you changed, sold, or gave away. Verifications should be sent with the form or uploaded to abe.illinois.gov
- Documentation you do not provide with this form will be requested later.
- See last page of this form for information about how and where to send the completed form (if applicable)

1. **In the past 60 months**, did you or your spouse; sell, give away or change ownership in any way to property? Yes ☐ No ☐

   Property includes; home, land or buildings, farmland, mineral rights, life estate, mobile home

   If yes, date of transaction and amount received? _____

   Provide documentation to verify the transaction, including the value at the time of the transfer. ***Examples*** of acceptable documentation are; settlement statement, deed, tax assessment that correlates with the year of the transaction, statement from reputable realtor, appraisal, market analysis.

2. **In the past 60 months**, did you or your spouse; close, give away or change ownership in any way to any of the following? Yes ☐ No ☐

Account Type	Institution Name	Date	Amount
Checking/Savings			
Christmas Club			
Certificate of Deposit			
Investment or Retirement account (money market, mutual fund, IRA, 401K, deferred comp, other)			
Stocks/Bonds			
Other			

Provide documentation to verify the transaction/s

3. **In the past 60 months**, did you or your spouse sell, give away or change ownership in any way pertaining to a vehicle/s? Yes ☐ No ☐

   If yes, what type of vehicle? _____

   Date of transaction and amount received? _____

   Provide documentation to verify the transaction, including the value at the time of the transfer. ***Examples*** of acceptable documentation are: bill of sale, copy of signed title, signed statement from the buyer, copy of check from buyer.

4. **In the past 60 months**, did you or your spouse sell, give away or change ownership in any way pertaining to a business? Yes ☐ No ☐

   Business includes but is not limited to: home based business, farm, partnership, sole ownership, corporation, limited liability, sole proprietorship.

   If yes, name of business? _____

   Date of transaction and amount received? _____

   Provide documentation to verify the transaction, including the value at the time of the transfer. ***Examples*** of acceptable documentation are: name of business, the value of you or your spouses' ownership interest in the business, date of the transaction, profit and loss statements relative to time of transfer, tax returns.

5. **In the past 60 months**, did you or your spouse: sell, give away or change ownership in any way to business equipment? Yes ☐ No ☐

   Business equipment includes but is not limited to: farm equipment, livestock, grain, wind turbines, computers, office equipment, any equipment used to run the business

   If yes, date of transaction and amount received? _____

   Provide documentation to verify the transaction, including the value at the time of the transfer. ***Examples*** of acceptable documentation should include type of equipment, value of equipment and date of transaction.

6. **In the past 60 months**, did you or your spouse receive rental income or income from a farm lease/ cash rent? Yes ☐ No ☐

   If yes, date and amount of most recent income received _____

   Provide a copy of the rental/lease agreement and verification of the income received.

7. **In the past 60 months**, did you or your spouse take out a loan or a reverse mortgage?

   Yes ☐ No ☐

   If yes, date and amount of most recent income received _____

   Loan includes but is not limited to personal loans to friends or family.

8. **In the past 60 months**, did you or your spouse enter into an agreement with anyone such as a: mortgage agreement, promissory note or contract for deed? Yes ☐ No ☐

   Include anyone who owes you or your spouse money with an agreement to repay.

   If yes, date loan was made _____ Amount of loan $ _____

   Provide a copy of all promissory notes, mortgage agreements or contracts for deed.

9. **In the past 60 months**, have you or your spouse purchased an annuity? Yes ☐ No ☐

If yes, date of purchase _____
Provide a copy of all annuity contracts

10. **A. In the past 60 months**, did you or your spouse inherit anything including but not limited to: money, property, stocks, bonds, etc Yes ☐ No ☐

If yes, date and amount received _____

Name of deceased person _____

Relationship to deceased person _____

Date of death _____

Provide documentation of the inheritance
Examples of acceptable documentation include: all distributions of an estate settlement, life insurance death benefit payout.

B. In the past 60 months, did you or your spouse decline receipt of an inheritance? For example, did you or your spouse receive an inheritance and waive your right to receive it so the inheritance would go to your children? Yes ☐ No ☐

If yes, provide a brief explanation including the amount you declined.

11. **A.** Do you or your spouse have a trust? Yes ☐ No ☐

If yes, date established _____
Provide a copy of the trust agreement and include a list of all the resources held in the trust.

B. In the past 60 months, did you or your spouse add resources to that trust? Yes ☐ No ☐

If yes, date and type of resource/s added _____

12. **A. In the past 60 months**, did you or your spouse establish a trust for someone else?
Yes ☐ No ☐

If yes, date established and name of trust? _____
Provide a copy of the trust.
Are you or your spouse related to this person? Yes ☐ No ☐

If yes, what is your relationship to this person? _____
Is this person disabled as defined by the Social Security Administration? Yes ☐ No ☐
If yes, provide copy of letter from Social Security Administration.

B. In the past 60 months, did you or your spouse add your resources to the trust including at the time established? Yes ☐ No ☐

If yes, date, type and amount of resources/s added? _____

13. Have you met with a financial planner, estate planner or other professional to discuss or get help with any of the following? Yes ☐ No ☐

a. How to use your income and resources to pay for a nursing home or supportive living program facility
b. How to apply for medical assistance
c. Plan for dividing your resources between family members or other heirs
d Plan for placing your resources in a trust.

Provide the following information about the person or group

Name		Name	
Address		Address	
Email Address		Email Address	
Phone		Phone	

Stop Here

You are not required to complete or return this form if you have:

- **received medical benefits from the State of Illinois for *6 months or longer* immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services and**
- **you answered NO to Every question 1-13.**

You are required to complete and return this form if you are:

- **applying for medical benefits and you need help with Nursing Home or Supportive Living Program services or Department on Aging Home and Community Based Services;**
- **received medical benefits from the State of Illinois for *less than 6 months* immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services; or**
- **received medical benefits from the State of Illinois for *6 months or longer* immediately prior to moving to a Nursing Home or Supportive Living Program facility or requesting Department on Aging Home and Community Based Services and you answered YES to at least one of the questions 1-13.**

Notice will be sent to all persons approved to receive assistance with nursing home, supportive living program services and Department on Aging Home and Community Based Services.

14. Do you or your spouse have an interest in a Time Share? Yes ☐ No ☐

If yes, provide documentation about the time share.

15. Do you have an insurance policy that pays for nursing home care when you are in a nursing home?
Yes ☐ No ☐
If yes, name of insurance company and policy number _____
Who receives the benefit payments from the insurance company? Nursing home ☐ You ☐
Someone else ☐ If someone else, provide name of person _____
Provide a copy of your policy agreement that **gives details about the payments** including; daily benefit rate, length of coverage, any special circumstances. Documentation should also include policy number, name and address of insurance company.
You do not need to provide a copy of the entire policy.

16. Have you filed a federal income tax return in the past 60 months? Yes ☐ No ☐
In which years? _____ _____ _____ _____ _____
Provide a copy of your tax returns including attachments and 1099's filed in the past 60 months.

17. What is your current marital status?
Single ☐ Married ☐ Divorced ☐ Widowed ☐ Legally Separated ☐
Provide information about your current or most recent spouse.
Name _____ Phone _____
Address _____

18. Provide the addresses of the last two places you lived in the past 60 months:
Address #1 _____
Address #2 _____

19. Have you designated someone to be your:
- **Power of Attorney (POA) for Financial Affairs** *(not to be confused with POA for Health)*?

Yes ☐ No ☐
If yes, provide a copy of your Financial POA papers
- **Guardian** Yes ☐ No ☐

If yes, provide a copy of guardianship papers
- **Authorized/Approved Representative** (*Not including POA, guardian or person/group named in #13*

Yes ☐ No ☐
If yes, provide a copy of the authorized/approved representative papers.
- Has someone (friend, family member) been helping you with your financial affairs but they are not a designated POA, guardian or authorized representative? Yes ☐ No ☐

If you answered yes to any of the above, provide the following information:

Name		Name	
Address		Address	
Email Address		Email Address	
Phone		Phone	

I, the undersigned, hereby certify and swear, that all information on this form is true, accurate and complete. I understand that the information on this form may be used to determine eligibility for medical assistance and that payments will be made from state and federal funds. Any false statements, or documents, or concealment of material fact may be cause for prosecution or other appropriate legal action.

The undersigned hereby consents and authorizes Illinois Department of Healthcare and Family Services and Department of Human Services to investigate, obtain and verify all information necessary in connection with the request for public assistance. Such information shall include, but not be limited to, documents of financial institutions, trusts, insurance, stocks/mutual funds, real estate, pension, SSI/SSA, and any other type of financial resources. Failure to cooperate or provide documentation or information may result in the denial of assistance.

SIGN YOUR NAME OR MAKE YOUR MARK:

Applicant	Date
Spouse	Date

CONTACT INFORMATION

Nursing Home or Supportive Living Program

Medical Field Operations North
If you are requesting assistance for Nursing Home Services, Supported Living Program and you live in **Cook** County send completed form to:

Medical Field Operations North
1112 S. Wabash
Chicago, IL 60605-2351
Phone: 312-793-8000
Fax: 312-793-4566
DHS.MFOInfo@illinois.gov

Medical Field Operations Central
If you are requesting assistance for Nursing Home Services, Supported Living Program and you live in one of the following counties: **Boone, Bureau, Carroll, Champaign, DeKalb, DuPage, Ford, Fulton, Grundy, Henderson, Henry, Iroquois, Jo Davies, Kane, Kankakee, Kendall, Knox, Lake, LaSalle, Lee, Livingston, Marshall, Mason, McHenry, McDonough, McLean, Mercer, Ogle, Peoria, Putnam, Rock Island, Stark, Stephenson, Tazewell, Vermilion, Warren, Whiteside, Will, Winnebago or Woodford** send completed form to:

Medical Field Operations Central
1642 West 59th Street, 1st Fl
Chicago, IL 60636
Phone: 773-863-6339
Fax: 773-863-6307
DHS.MFOCentral@illinois.gov

Medical Field Operations Downstate
If you are requesting assistance for Nursing Home Services, Supported Living Program and you live in one of the following counties: **Adams, Alexander, Bond, Brown, Calhoun, Cass, Christian, Clark, Clary, Clinton, Coles, Crawford, Cumberland, De Witt, Douglas, Edgar, Edwards, Effingham, Fayette, Franklin, Gallatin, Greene, Hancock, Hamilton, Hardin, Jackson, Jasper, Jefferson, Jersey, Johnson, Lawrence, Logan, Macon, Macoupin, Madison, Marion, Massac, Menard, Montgomery, Monroe, Morgan, Moultrie, Perry, Piatt, Pike, Pope, Pulaski, Randolph, Richland, Saline, Sangamon, Schuyler, Scott, Shelby, St Clair, Union, Wabash, Washington, Wayne, White, or Williamson** send completed form to:

Medical Field Operations Downstate
707 E Wood Street
Decatur, IL 62523
Phone and Fax: 217-362-6515
DHS.MaconLTC@illinois.gov

Department on Aging Home and Community Based Services

If you are requesting assistance for Department on Aging, Home and Community Based Services send completed form to the Family Community Resource Center (FCRC) in the county where you live or give the completed form to your Community Care Partner case manager.