VIRGINIA GAY
NURSING & REHAB

Virginia Gay Nursing & Rehab, LLC
502 North Ninth Avenue | Vinton, Iowa 52349 | 319-472-6280

Thank you for your inquiry into Virginia Gay Nursing and Rehab. In order to facilitate admission, this document will explain the requirements for admission and the methods of payment for long-term care. After your application is processed and a bed becomes available, our social worker will contact you to schedule a home visit designed for us to become familiar with your loved one to better meet their needs. Personal tours can also be scheduled at your convenience by calling 319-472-6280.

Prior to admission, we require the following:

- A fully completed Application for Admittance, Veterans Affairs Worksheet, and Advance Directives
- A negative TB test, Quantiferon Gold Test, or a chest x-ray that your doctor reads and notes on the document that there is no evidence of active TB
- An admission physical or a History and Physical from your primary care physician or a doctor in the hospital that states your medications, current and prior health conditions and surgeries
- Screening for mental and physical health care needs to determine if there are special needs and requirements and if the facility is able to manage those needs and requirements
- Screening on the Iowa Sex Offender Registry

Payment Agreement

Residents accepted for admittance who will be paying for nursing home services privately or who have nursing home insurance will be responsible to pay a Security Deposit and advance payment for remaining days in the month as follows. Please select your room preference for consideration.

☐ Semi-Private Room:
$9,900.00 Security Deposit plus $330/day for the remaining days of the month

☐ Private Room:
$10,200 Security Deposit plus $340/day for the remaining days of the month

☐ Private Suite:
$10,650.00 Security Deposit plus $355/day for the remaining days of the month

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To assist us to determine how best to meet the resident needs, please select one of the following. Check all that apply:

- ☐ The resident has a long-term care insurance policy
  - Nursing Home Insurance Company Name: ……
  - Policy Number: ……
  - Phone Number: ……..

- ☐ The resident has greater than $100,000 in cash and assets and does not need to consider Medicaid assistance for at least one year

- ☐ The resident has more than $50,000 in cash and assets and needs to consider Medicaid assistance within the next 6 months

- ☐ The resident has more than $20,000 and needs to consider Medicaid assistance within the next 3 months

- ☐ The resident has less than $20,000. Once the Security Deposit and the remaining days of the first month are paid, the resident needs to apply for Medicaid Assistance

- ☐ The resident does not have enough money to pay the Security Deposit and the remaining days of the month and needs to apply for Medicaid (Please submit proof of income and assets in the form of bank statements, property descriptions, etc. or complete a Verification of Deposit for each bank the resident uses so the facility can verify balances)

- ☐ The resident currently has Medicaid Assistance

Residents who are enrolled in Medicaid are responsible to pay an amount each month of their stay. This is called Client Participation and the amount is set by the Department of Human Services (DHS). It is usually $50.00 less than the amount of the resident's social security check and any allowances for insurance premiums. Your case worker will have more information on the amount of Client Participation that is owed to the facility each month, so any questions regarding Client Participation should be directed to DHS. If the resident has Title 19 or until DHS makes the determination that the resident is eligible and approved for Title 19, they will be responsible to make a monthly payment of $50.00 less than their social security check and insurance premiums. This will be due upon admission.

Income:	.....
Personal Allowance:	$50.00
Insurance Premiums:	.....
Part D Plan:	.....
Estimated CP:	.....

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If DHS determines the amount due is less than what was paid, the facility will refund the difference, or if the amount is greater, the resident will owe the difference. If there is non-payment on any account after a two-month period and there has been no payment arrangement made with the business office, the facility will notify the resident that they will be discharged from the facility due to non-payment.

I have read and understand the financial obligation and agree to the terms stated above. I am aware that failure to make payment for services rendered will result in discharge to the facility due to non-payment.

Please call the Business Office at 319-472-6448 if you have questions or need additional information.

Residents Name: .....

Resident/Responsible Party Signature: .....

Date: .....

Facility Representative Signature .....

Date:.....

Application for Admittance

This application does not constitute an admission agreement. Information submitted herein will be reviewed by administration to determine if further admittance procedures are advisable. No obligation is placed on either the Applicant or Facility through submission of this form. However, if admission is deemed advisable, the information submitted on the application will become pertinent to admittance and will become a part of the overall agreement. False or misleading statements may nullify any and all future agreements. Please print plainly.

Last Name: ..... First Name: ..... Middle Name: .....

Present Address: ..... Daytime Phone: .....

Date of Birth: ..... Place of Birth: ..... Marital Status: .....

Social Security No.: ..... Medicare No.: ..... Medicaid No.: .....

Supplemental Insurance Name and Policy No. .....

Prescription Drug Plan Name and Policy No: ....

Highest Level of Education: .....Prior Occupation: .....

Name and Address of Current Physician: ..... Phone No.: .....

Chose a Physician to care for Resident after Admission: ☐ Dr. Meeker ☐ Dr. Song ☐ Dr. Elgin ☐ Dr. Silbernagel

Name and Address of Eye Doctor: ..... Phone No.: .....

Name and Address of Dentist: ..... Phone No.: .....

Local Pharmacy of Choice (check one): ☐ LaGrange Pharmacy ☐ VA Medication Phone No.: .....

Barber/Beautician: ☐ Becky Decker/The Golden Comb : ☐ BeckMary Barkdoll ☐ Other/Family (Please specify): .....

Hospital of Choice: ..... Phone No.: .....

Church Membership and Town: .....

Pastor: ..... Phone No.: .....

Funeral Home Preference/Address: ..... Phone No.: .....

Please also submit the following documents: ☐ Living Will ☐ Insurance Cards ☐ Medical/General Power of Attorney

Resident Representative/Emergency Contact #1: Person designated to make decisions on behalf of the applicant. The person listed will be the primary contact for the applicant. If there is a Medical Power of Attorney, the person designated should be the Resident Representative:

Name: ..... Email Address: .....

Relationship to Resident: .....Address: .....

Home Phone: ..... Work Phone: ..... Cell Phone: .....

Is the person listed above (check all that apply): ☐ Medical Power of Attorney ☐ General Power of Attorney ☐ Legal Guardian ☐ None of These

Emergency Contact #2: Name: ..... Email Address: .....

Relationship to Resident: .....Address: .....

Home Phone: ..... Work Phone: ..... Cell Phone: .....

Is the person listed above (check all that apply): ☐ Medical Power of Attorney ☐ General Power of Attorney ☐ Legal Guardian ☐ None of These

Emergency Contact #3: Name: ..... Email Address: .....

Relationship to Resident: .....Address: .....

Home Phone: ..... Work Phone: ..... Cell Phone: .....

Is the person listed above (check all that apply): ☐ Medical Power of Attorney ☐ General Power of Attorney ☐ Legal Guardian ☐ None of These

Designate who is to receive the monthly bill: ..... Email Address: .....

Relationship to Resident: .....Address: .....

Home Phone: ..... Work Phone: ..... Cell Phone: .....

Is the person listed above (check all that apply): ☐ Medical Power of Attorney ☐ General Power of Attorney ☐ Legal Guardian ☐ None of These

AUTHORIZATION:

By my signature below, I hereby authorize the nursing home to contact the county social services for information regarding my Medicaid application and eligibility, and I hereby release and authorize the county social services to release any information to the nursing home. I also authorize the nursing home to contact any and all of the above-identified financial institutions to obtain information regarding my assets and income, and I hereby release and authorize the financial institutions to release any information to the nursing home. I further authorize the nursing home to release to its attorneys any information regarding my application for admission.

I understand that providing false information could result in discharge and/or denial of my application. The answers provided herein are true and correct to the best of my knowledge and information.

Printed Name of Person Completing Application: .....

Signature of Person Completing Application: ..... Date: .....

ADVANCE DIRECTIVE: Treatment Choices

Treatment or Procedure		
Choice	**Want**	**Do Not Want**
Antibiotics		
AND (Allow Natural Death)		
Pain Medication		
Artificial Hydration		
Artificial Nutrition		
Blood Transfusions		
(CPR) Cardiopulmonary Resuscitation		
Advanced Cardiac Life Support		
Respirator/ Ventilator		

The following definitions are to assist you in making the treatment choices listed on the left side of this page.

Antibiotics — Providing medications to fight infections.

AND — Allowing natural death to occur due to multisystem failure with a decline in condition. Marking Do Not Want means that would want to initiate mechanical resuscitation. (CPR)

Pain Medications — Providing medication to maintain comfort even if it may lead to reduced consciousness and/or shorten life.

Artificial Hydration — Providing fluids through a tube into the vein, nose or stomach.

Artificial Nutrition — Providing nutrition through a tube into the vein, nose or stomach.

Blood Transfusions — Providing blood through a tube into the vein.

(CPR) Cardiopulmonary Resuscitation — Emergency medical procedures such as manual compression of the chest to stimulate the heart and/or providing air into the lungs.

Advanced Cardiac Life Support — Emergency medical procedures such as tube into mouth and nose to assist in breathing, medications into vein or heart and/or electrical stimulation of the heart muscle.

Respirator/Ventilator — Use of a mechanical device to assist breathing.

Additional comments: .....

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The above are my choices as of this date.

Signature: ..... Date: .....

Witness: ..... Date: .....

Physician: ..... Date: .....

Virginia Gay Nursing & Rehab is required to submit the following information to Veterans Affairs per Iowa Code, Section 135C31A as we are a licensed long-term care facility that receives reimbursement through the Medicaid (Title 19) Program. This information is used to assist the Iowa Department of Veterans in identifying residents who are or may become eligible for benefits through the US Department of Veterans Affairs. Please note this information must be submitted with application for continuation of admission process.

Residents Name: .....

Applicant Type:
- ☐ Veteran
- ☐ Veteran's Spouse
- ☐ Veteran's Dependent
- ☐ Veteran's Widow(er)
- ☐ Non-Veteran Resident (check if applicant or spouse has not served in the armed services)

Veterans Information: Name: .....

Date of Birth: .....

Social Security Number:.....

Branch of Service:
- ☐ US Air Force
- ☐ US Army
- ☐ US Coast Guard
- ☐ US Marine Corps
- ☐ US Navy
- ☐ Air National Guard
- ☐ US Merchant Marines
- ☐ US Air Force Reserves
- ☐ US Army Reserves
- ☐ US Coast Guard Reserves
- ☐ US Marine Corps Reserves
- ☐ US Navy Reserves
- ☐ Army National Guard

Service Dates: (m/d/y) Enter: ..... Depart: .....

Discharge Type:
- ☐ Honorable
- ☐ Dishonorable
- ☐ General Under Honorable Conditions
- ☐ Under other than Honorable Conditions
- ☐ Uncharacterized
- ☐ Bad Conduct

Served in :
- ☐ WWI
- ☐ Korean Conflict
- ☐ Gulf War
- ☐ Retired
- ☐ Other
- ☐ Explain:.....
- ☐ WWII
- ☐ Vietnam War
- ☐ Peace Time

Is veteran or widow currently receiving benefits?
- ☐ Prescriptions
- ☐ Treatments
- ☐ Monetary Amount:.....

Resident/Responsible Party Signature: ..... Date: .....