Presbyterian Home
Hawfields
2502 South NC 119 • Mebane, North Carolina 27302
(336) 578-4701

Thank you for the interest you have shown in the Presbyterian Home of Hawfields. In addition to the following information, an application is available from the Business Office.

The following are the rates (per day) for private pay. If you are eligible for Medicaid, you must contact your County Social Service Department, which will make the financial arrangements.

NURSING CARE

| | |
|---|---|
| Semi-Private Room | $200.00 per day |
| Private Room | $215.00 per day |
| Semi-Private as Private Room | $225.00 per day |

INDEPENDENT LIVING

| | |
|---|---|
| Semi-Private Room | SEE ATTACHED |
| Private Room | SHEET |

All rates include three (3) meals per day. Extra meals may be purchased for family and friends.

These rates are effective April 1, 2013. These rate are subject to change with a 30 days notice given to the Residents.

The completed application is the first step in being considered for placement. For your convenience the fax number is (336) 578-4728. Applications are kept on file and reviewed by the Admissions Staff when beds are available. You will be contacted when your application is being considered for placement.

After the application is completed in it's entirety, you may call during business hours if you have any questions or if you would like to make an appointment.

Presbyterian Home
Hawfields
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(336) 578-4701

Effective October 1, 2003, the following levels of service are hereby established for the stated rates:

1. RATE SCHEDULE #1

Private - $45.00 per day
Couples may inquire about special rates

For the above rates, you will receive the following accommodations:

A. Three (3) meals a day are provided. Your guests may purchase meal tickets at a very reasonable price.

B. Weekly housekeeping services.

C. As needed trash pick-up.

D. Bed linens, bath towels, and washcloths (if desired).

E. Unlimited and free use of two domestic washers and dryers, or for an extra fee, the facility will provide regular laundry services for your personal clothes.

F. Individual room heaters, air conditioning, showers and bathrooms.

G. Activities and religious events (such as prescheduled facility-wide group Mall trips and other special outings).

H. Cable TV

I. Private phone jacks. (YOU must supply your own phone and service, which the facility will coordinate through BellSouth.)

J. Private (reserved) parking spaces.

And K. 24-hour access to your room for yourself and visitors (no restriction on visiting hours); you will have a key to your own room for security purposes. The main entrance door are locked at night.

2. RATE SCHEDULE #2
Rate Schedule #1, plus an additional charge of $25.00 per month (per service)

For the above rates, you will receive all of the accommodations listed in Rate Schedule #1, plus *once-a-week* services by licensed nurses (such as allergy shots, etc.). You may be required to walk to the Nursing Area to receive these weekly services.

3. RATE SCHEDULE #3 Effective October 1, 2011

Private - $108.00 per day
Couples may inquire about special rates

For the above rates, you will receive all the accommodations listed in Rate Schedule #1, plus *daily* administration of medications by Nursing personnel. We reserve the right to refuse to pass medications if determined by Director of Nursing to require excessive nursing time.

# APPLICATION

Please fill out the information completely. Application must be complete before it can be processed. If you have questions, please call (336) 578-4701. Thank you.

NAME_____ AGE_____

DATE OF BIRTH_____ RACE_____

ADDRESS_____

TELEPHONE(___)_____ MARITAL STATUS: S____ M____ D____ W_____

SOCIAL SECURITY_____ RELIGION_____

PAST OCCUPATION_____
ADMISSION FROM: HOME_____
NURSING HOME-(within last 60 days): Admission date: _____
Discharge date: _____
HOSPITAL-(admission date):_____
OTHER_____

**Where did you hear about our facility?**_____

## TYPE OF ACCOMMODATIONS DESIRED

A. NURSING CARE: PRIVATE_____ SEMI-PRIVATE_____
B. INDEPENDENT LIVING: PRIVATE_____ SEMI-PRIVATE_____

- ***Independent Living is not covered by Medicare/Medicaid or Insurance***

## INSURANCE INFORMATION

Medicare Number_____ Medicaid Number_____
Health Insurance: Name of Company_____
Member Number _____

- **We need copies of the front & back of insurance & Medicare Cards**

## EMERGENCY INFORMATION

PHYSICIAN'S NAME_____ PHONE #_____

RESPONSIBLE PARTY_____ RELATIONSHIP_____
ADDRESS_____ CITY_____
STATE_____ ZIP_____ TELEPHONE # HOME_____
WORK_____

OTHER CONTACT PEOPLE:

NAME _____ RELATIONSHIP_____
TELEPHONE # HOME_____ WORK_____
NAME_____ RELATIONSHIP_____
TELEPHONE # HOME_____ WORK_____

## FINANCIAL INFORMATION

Cash on hand & in banks $_____

All Securities

_____ $_____

_____ $_____

_____ $_____

Accounts & Notes Receivable:

_____ $_____

_____ $_____

Real Estate Owned: $_____

Cash Value - Life Ins. $_____

Automobiles: $_____

Personal Property: $_____

TOTAL LIABILITIES:$_____

TOTAL ASSETS: $_____

SOURCES OF INCOME

Salary: $_____

Bonus & Commissions: $_____

Dividends: $_____

Real Estate Income: $_____

Social Security Income: $_____

Other Income-Itemize: $_____

_____ $_____

_____ $_____

TOTAL: $_____

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Is there a Representative Payee for the applicant? Yes_____ No_____

If yes, who_____ Relationship_____

If no, who is receiving the checks?_____ Relationship_____

Are you a US Citizen? Yes_____ No_____

Has an application been made for Medicaid? Yes_____ No_____

If yes, date applied_____ Caseworker_____

Social Services Department_____

If no, will an application be made? Yes_____ No_____ If yes, when_____

Funeral Home Preference_____ City_____

Has applicant taken care of pre-burial expenses? Yes_____ No_____

Is applicant under a contract with Hospice? Yes_____ No_____

Is there a trust account held for this applicant Yes_____ No_____

If yes, administered by whom?_____

Is the applicant fully aware that the application is being made for placement on his/her behalf?

Yes_____ No_____ If no, why?_____

_____.

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**Does applicant have any of the following:**

_____Living Will

_____Healthcare Power of Attorney

_____Financial Power of Attorney

- **We need copies for Resident's file**

**If applicant is admitted would you want them to have NO CODE ORDER**

_____ **Yes** _____ **No**

Past Hospitalization and received treatment for Physical or Mental Illness/s?

_____ _____

Date Reason for Stay

I have read the above and declare that there is no injury, illness, or ailment other than as specifically herein noted. I hereby give permission for follow-up with the physician to clarify any answers given above.

If it should be found that deception has been practiced in any matters pertaining to the Home by the applicant, this will be sufficient grounds for the Admissions Committee to reconsider the case.

_____

APPLICANT SIGNATURE/PERSON SIGNING FOR APPLICANT

_____

DATE

The submission of this application must be accompanied by the following information:

A. Copies of all insurance eligibility cards – Medicare, Medicaid, Blue Cross/Blue Shield, any secondary insurance.
B. Copy of Power of Attorney, Healthcare Power of Attorney, Living Will and Trust Account if applicable.

FL-2 (86)
INSTRUCTIONS ON REVERSE SIDE

# NORTH CAROLINA MEDICAID PROGRAM
# LONG TERM CARE SERVICES

☐ PRIOR APPROVAL ☐ UTILIZATION REVIEW ☐ ON-SITE REVIEW

## IDENTIFICATION

| 1. PATIENT'S LAST NAME | FIRST | MIDDLE | 2. BIRTHDATE (M / D / Y) | 3. SEX | 4. ADMISSION DATE (CURRENT LOCATION) |
|---|---|---|---|---|---|
| | | | | | |

| 5. COUNTY AND MEDICAID NUMBER | 6. FACILITY | ADDRESS | 7. PROVIDER NUMBER |
|---|---|---|---|
| | | | |

| 8. ATTENDING PHYSICIAN NAME AND ADDRESS | 9. RELATIVE NAME AND ADDRESS |
|---|---|
| | |

| 10. CURRENT LEVEL OF CARE | 11. RECOMMENDED LEVEL OF CARE | 12. PRIOR APPROVAL NUMBER | 14. DISCHARGE PLAN |
|---|---|---|---|
| ___ HOME ___ DOMICILIARY (REST HOME) | ___ HOME ___ DOMICILIARY (REST HOME) | | ___ SNF ___ HOME |
| ___ SNF | ___ SNF | | ___ ICF |
| ___ ICF ___ OTHER | ___ ICF ___ OTHER | 13. DATE APPROVED / DENIED | ___ DOMICILIARY (REST HOME) |
| ___ HOSPITAL _____ | _____ | | ___ OTHER _____ |

## 15. ADMITTING DIAGNOSES - PRIMARY, SECONDARY, DATES OF ONSET

| | |
|---|---|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

## 16. PATIENT INFORMATION

| DISORIENTED | AMBULATORY STATUS | BLADDER | BOWEL |
|---|---|---|---|
| ☐ CONSTANTLY | ☐ AMBULATORY | ☐ CONTINENT | ☐ CONTINENT |
| ☐ INTERMITTENTLY | ☐ SEMI-AMBULATORY | ☐ INCONTINENT | ☐ INCONTINENT |
| **INAPPROPRIATE BEHAVIOR** | ☐ NON-AMBULATORY | ☐ INDWELLING CATHETER | ☐ COLOSTOMY |
| ☐ WANDERER | **FUNCTIONAL LIMITATIONS** | ☐ EXTERNAL CATHETER | **RESPIRATION** |
| ☐ VERBALLY ABUSIVE | ☐ SIGHT | **COMMUNICATION OF NEEDS** | ☐ NORMAL |
| ☐ INJURIOUS TO SELF | ☐ HEARING | ☐ VERBALLY | ☐ TRACHEOSTOMY |
| ☐ INJURIOUS TO OTHERS | ☐ SPEECH | ☐ NON-VERBALLY | ☐ OTHER: |
| ☐ INJURIOUS TO PROPERTY | ☐ CONTRACTURES | ☐ DOES NOT COMMUNICATE | ☐ O2 PRN CONT. |
| ☐ OTHER: | **ACTIVITIES SOCIAL** | **SKIN** | **NUTRITION STATUS** |
| **PERSONAL CARE ASSISTANCE** | ☐ PASSIVE | ☐ NORMAL | ☐ DIET |
| ☐ BATHING | ☐ ACTIVE | ☐ OTHER: | ☐ SUPPLEMENTAL |
| ☐ FEEDING | ☐ GROUP PARTICIPATION | ☐ DECUBITI-DESCRIBE: | ☐ SPOON |
| ☐ DRESSING | ☐ RE-SOCIALIZATION | | ☐ PARENTERAL |
| ☐ TOTAL CARE | ☐ FAMILY SUPPORTIVE | | ☐ NASOGASTRIC |
| **PHYSICIAN VISITS** | **NEUROLOGICAL** | | ☐ GASTROSTOMY |
| ☐ 30 DAYS | ☐ CONVULSIONS/SEIZURES | | ☐ INTAKE AND OUTPUT |
| ☐ 60 DAYS | ☐ GRAND MAL | ☐ **DRESSINGS:** | ☐ FORCE FLUIDS |
| ☐ OVER 180 DAYS | ☐ PETIT MAL | | ☐ WEIGHT |
| | ☐ FREQUENCY | | ☐ HEIGHT |

| 17. SPECIAL CARE FACTORS | FREQUENCY | SPECIAL CARE FACTORS | FREQUENCY |
|---|---|---|---|
| ☐ BLOOD PRESSURE | | ☐ BOWEL AND BLADDER PROGRAM | |
| ☐ DIABETIC URINE TESTING | | ☐ RESTORATIVE FEEDING PROGRAM | |
| ☐ PT (BY LICENSED PT) | | ☐ SPEECH THERAPY | |
| ☐ RANGE OF MOTION EXERCISES | | ☐ RESTRAINTS | |

## 18. MEDICATIONS NAME & STRENGTHS, DOSAGE & ROUTE

| | |
|---|---|
| 1. | 7. |
| 2. | 8. |
| 3. | 9. |
| 4. | 10. |
| 5. | 11. |
| 6. | 12. |

19. X-RAY AND LABORATORY FINDINGS / DATE:

20. ADDITIONAL INFORMATION:

| 21. PHYSICIAN'S SIGNATURE | 22. DATE |
|---|---|
| | |

372-124 (12-92)

**EDS - DMA COPY**