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
Rehabilitation Private Room	$350.00 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.

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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	$_____	SOURCES OF INCOME	
All Securities			
_____	$_____	Salary:	$_____
_____	$_____	Bonus & Commissions:	$_____
_____	$_____	Dividends:	$_____
Accounts & Notes Receivable:		Real Estate Income:	$_____
_____	$_____	Social Security Income:	$_____
_____	$_____	Other Income-Itemize:	$_____
Real Estate Owned:	$_____	_____	$_____
Cash Value - Life Ins.	$_____	_____	$_____
Automobiles:	$_____	TOTAL:	$_____
Personal Property:	$_____		

TOTAL LIABILITIES:$_____
TOTAL ASSETS: $_____

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?_____
_____.

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