

**CORNER STONE PERSONAL CARE HOME  
ADMISSION RECORD**

Please complete this application so that we may have sufficient background in order to determine compliance with the residency requirements. Our Community will hold this information in the strictest confidence.

**PLEASE PRINT**

**PERSONAL INFORMATION:**

Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status (Circle One): S M W D

Monthly Rate For Care \_\_\_\_\_

Monthly Rate Due Date \_\_\_\_\_

Residents and Representative or legal surrogates must be informed in writing at least 60 days prior to changes in charges or services

Resident authorization and consent is required to release medical information to the home as needed

Residents will receive an admission assessment conducted by a licensed nurse/ administrator or on-site manager and continuous assessment of the residents needs, referral for appropriate services as may be required due to change in in resident's condition.

Provision for transportation of residents for shopping, recreation, rehabilitation and medical services, which must be available either as a basic service or on a reimbursement basis. Provision must also be made for access to emergency transportation at all times.

Residents who place a deposit for a bed hold with the intent to move in will be reimbursed within a 5 day period after which the deposit becomes nonrefundable

Resident who have paid their monthly fee and die or become unable to remain in the facility will receive a prorated refund based on number of days remaining in the month

Residents are not required to perform any services in the home in exchange for room and board . At no time are the residents to perform any household duties.

Resident will receive a copy of the house rules, which are also posted in the home. House rules must be consistent with residents rights. House rules must include but not be limited to policies regarding use of tobacco and alcohol, the times and frequency of use of the telephone, visitirs, hours, and vloume for viewing the television, radio and other audiovisual equipment, whether residents persona pets or household pets are permitted and the ue of personal property.

Residents are permitted to hire independent proxy caregivers, sitters, or requires the purchase of such services from the home or approved providers.

Residents are assisted with the **medication** by trained staff, All staff person will after being trained have to shown clearly that they understand and are capable of assisting clients with their medications per facility and state guidelines. All staff person upon observation have to demonstrate that they can safely assist with medications as well as perform proper documentation for each client. All staff must be able to state how to handle clients that refuse medication and how to properly document this on the Medication Administration Records. The staff are only permitted to assist but can not administer medications directly into the clients or residents mouth. This is done by taking the medication to the clients, reading what the medication is and opening the medication in front of the clients and placing the medication in a medication cup or directly into the clients hand and ensure the client has actually taken the medication and document immediately. The medication is read to the residents then placed in the hand of the resident and the resident must be able to place medication into their own mouths. Responsible parties are initially responsible to bring all medications ordered by physicians upon admission and are responsible upon notification by facility that medication is ready for pick up at the pharmacy of choice. If the facility has made payment to the pharmacy to obtain medication in order for resident not to run out the responsible party will then be billed on the next month to reimburse the facility. Residents are permitted to choose the pharmacy of their choice; however all medications must meet the order of the physician and be delivered in its original package. No over the counter medications will be allowed into the facility without the proper permission from the primary physician. Only licensed personnel will assist the clients with injectables with the exception of an emergency such as an epi pen.

In the event that the resident requires discharge from the facility. Unless it is a medical emergency the responsible party will be required to transfer the resident and their belongings from the facility. However the facility will assist in anyway to ensure the transfer goes as safe as possible.

Residents have the right to refuse to have their pictures used in the facility, on social media, on facility web site or any other form of media. At no time will pictures be used if resident or responsible party refuses or declines. From this point forward the resident and responsible party will be notified in writing before any pictures are taken. The exception is for medication management and 911 purposes as these are needed to properly identify the resident.

Prior to the execution of this admission agreement, residents and representative must have an opportunity to read the agreement. In the event that a resident is unable to read the agreement, the administrator or on-site manager must take special steps to assure communication of its content to the resident

The resident and responsible party will be given a signed copy of the agreement and a copy signed by both parties the resident and administrator or on-site manager must be retained in the residents file and maintained by the administrator or on-site manager of the home.

Additional Charges for Salon Services, Briefs, Medication Refills \_\_\_\_\_

Signature of Resident/Responsible Party \_\_\_\_\_  
Date \_\_\_\_\_

Signature of Administrator/On-Site Manager

**VETERAN STATUS:** \_\_\_\_\_ **BRANCH SERVED:** \_\_\_\_\_

**SPONSOR(S):** (Children, closest living relative or responsible party)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**PERSON(S) OR AGENCY PROVIDING ASSISTANCE TO THE RESIDENT:**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

**SPIRITUAL AFFILIATION:** Church/Synagogue: \_\_\_\_\_ Denomination: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

**PERSONAL PHYSICIAN:**

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Insurance Companies \_\_\_\_\_

**PHARMACY PREFERENCE:**

Pharmacy: \_\_\_\_\_ Telephone: \_\_\_\_\_

**FUNERAL ARRANGEMENTS & BURIAL PROVISIONS (information about insurance policies):**

\_\_\_\_\_  
\_\_\_\_\_

**DATE OF ADMISSION:** \_\_\_\_\_ **SIGNATURE:** \_\_\_\_\_

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**DATE OF DISCHARGE:** \_\_\_\_\_

**FACILITY, SETTING OR LOCATION TO WHICH DISCHARGED:** \_\_\_\_\_

**REASON/CAUSE FOR DISCHARGE:** \_\_\_\_\_