Fort Bayard Medical Center
Admission Information

Please print clearly

____

Last Name First Name Middle/Maiden Name

____

Mailing Address City State Zip County

Sex: Male Female Marital Status: ________________ Religion: ________________________

Date of Birth: ___________ Age: ___________ Birth Place: ____________________________________

Ethnicity: Anglo Hispanic Black Asian Native American Other: _______________________

Social Security #: ________________ Medicare #: ________________ Medicaid #: __________________

Insurance: ______________________ Insurance #: ________________ Occupation: __________________

Veteran: Y N Veteran Spouse: Y N VA Claim #: ____________________

Military related disability: Y N Military Branch of Service: ____________________

Military service from: ____________________ to: ___________________

Primary language: English Spanish Other: _______________________

Highest Level of Education (please be specific): ____

Parent/Spouse Information:

Father's Name: ____

Mother's Maiden Name: ____

Spouse's Name: ____ SS#: ______________________________

Lived alone: Y N If "no", with whom: ______________________________ Homeless: Y N

Next of Kin Name: _______________________________ Relationship: _______________________

____ Phone: Home: _______________________
Mailing address

Work: _______________________

____
City State Zip Other: _______________________
Does next of kin live with client: Y N

Responsible Party for Health Care Decisions (indicate if self):

____ Relationship: ________________________
Name

____ Phone: Home: ______________________
Mailing address:

Work: ______________________

____
City State Zip Other: ______________________

Responsible Party for Financial Decisions (indicate if self):

____ Relationship: _______________________
Name

____ Phone: Home: ______________________
Mailing address

Work: ______________________

____
City State Zip Other: ______________________

Contact in Case of Emergency:

____ Relationship: _______________________
Name

Phone: Home: ______________________

____
Mailing address Work: ______________________

____ Other: ______________________
City State Zip

Referral Source:

Referred by: ____

____
Address State Zip Phone #:

Has applicant ever been in a Nursing Home before? Yes No

If "yes", where? ____

Has placement been attempted at a facility closer to the applicant's home or relative's home? Y N

If "yes", when, where and why was placement not made? ________________________________
____
____

Name of Guardian, Conservator or Power of Attorney for the applicant?

Guardian: ____

Conservator: ____

Power of Attorney: ____

FOR OFFICIAL USE ONLY:

Medical Record #: ___________________ Unit: _______________ Room/Bed: __________________

Admission Date: _____________________ Admission Time: ___________________________

Previous Admission: ___________________ Attending Physician: ________________________

Admitted from: ____

FORT BAYARD MEDICAL CENTER
SKILLED NURSING/LONG TERM CARE DIVISION
ADMISSION AGREEMENT

Name of Resident: ________________________________ DOB: _______________________

I consent to admission to Fort Bayard Medical Center Long Term Care Division (Nursing Facility). I acknowledge that I will be under the care of an attending physician(s) and the colleagues of such physician(s).
I understand and agree to the conditions of admission listed below.

Consent for Care and Treatment

Consent for Routine Care

I hereby consent to routine nursing and medical care ordered by the attending physician and/or designated alternate. Examples of such routine care include bowel care; medications for constipation, mild diarrhea, indigestion, relief of mild pain and fever; diuretics; vitamins and minerals; topical anti-infective medications; I&O catheterization for urinalysis; sunscreen; skin care; nail care; special shampoo; diet/snacks; routine oral examination; routine audiological examinations, routine diabetic monitoring; physical, occupation and speech therapy baseline assessments; adjustments in medication within usual OBRA regulated ranges; routine diagnostic laboratory procedures and routine radiological procedures and recreational outings.

B. Consent for Treatment and Diagnostic or Therapeutic Procedures

I understand that each resident or his/her legal representative has the right to consent, or to refuse to consent to any proposed treatment, diagnostic or therapeutic procedures and no resident will be involved in any experimental procedure without his/her or the legal representative's full knowledge and consent. I understand that the registered pharmacists on a continuous basis monitor the medication regime of each resident and that the physician is immediately notified of any potential interactions or adverse effects.

I understand that ***specific consent will be requested*** of me for specialized treatment and diagnostic or therapeutic procedures. Examples of such include but are not limited to:
sleep medication; antipsychotic medications; antidepressants; anti-anxiety medications; mood stabilizers; and restraints.

I understand that if in the physician's clinical opinion a delay in initiating treatment would jeopardize my (resident's) health, treatment will be initiated immediately and the guardian (if applicable) will be notified as soon as possible thereafter.

Release of Information

I authorize Fort Bayard Medical Center to disclose all or any part of my record (in accordance with applicable policy and law) to health care facilities to which I may be transferred or to any entity that may be liable to Fort Bayard Medical Center for all or part of the facility's charges.

Personal Valuables

I understand that it is advised that I send valuables home or deposit them with Fort Bayard Medical Center for temporary safekeeping and security until alternate arrangements can be made.

Personal Furnishings and Equipment

I understand that I am allowed to keep personal possessions and equipment of my choice that meet space allocation and safety requirements. I also understand that any possessions kept be me at the time of admission, or acquired during my stay, will be my sole responsibility. Fort Bayard Medical Center bears no responsibility or liability for injuries, property damage or losses, which may result from my maintaining possessions or personal furnishings or equipment.

I HAVE ALSO READ AND UNDERSTAND THE RESIDENTS RIGHTS AND RESPONSIBILITIES AND THE FACILITY SMOKING POLICY.

I CERTIFY: This form has been explained to me; I have read the contents of the form or the contents have been read to me; I understand the contents; all items not applicable were stricken before I signed.

_______________________________________ _________________________
Signature of Resident Date

____
Witness

Resident cannot consent or authorize because ___________________________________
____

_______________________________________ _________________________
Signature of Legal Representative Date

____
Witness

FORT BAYARD MEDICAL CENTER

SSI/SS AUTHORIZATION

I authorize the Social Security Administration to release information about my record to:
Fort Bayard Medical Center for the purpose of admission to the facility.

The information to be released will include: benefits and/or Medicare coverage.

This consent is in effect indefinitely or until such time that I withdraw my authorization.

I authorize Fort Bayard Medical Center to serve as my "representative payee" to receive and help manage my benefits. The required amounts will be set aside each month for the beneficiary's personal needs. Amounts are subject to change.

The Social Security Administration will be notified promptly of a beneficiary's death or discharge from the facility. Upon termination of representative payee's responsibility, Fort Bayard Medical Center will return any conserved funds to the legal representative. There must be a will or a Quick Probate Claim in place.

Per Social Security Benefits, no check is payable for the month of death. If a check is received for the month of death or later, it will be returned. However, SSI checks are payable for the month of death and any SSI checks received after the month of death will be returned.

ASSIGNMENT OF BENEFITS

I request that payment of authorized benefits be made to me or on my behalf. I assign the benefits payable for physician services to the physician or organization furnishing the service or authorize such physician or organization to submit a claim to Medicare, Medicaid and private insurance for payment on my behalf.

MAIL CONSENT

I authorize Fort Bayard Medical Center staff, or designee, to receive, open and process mail addressed to the above name resident from Medicare, Medicaid, Insurance or any other financial source. I understand that all personal mail, not involving financial matters, will be delivered to me by the neighborhood's Social Worker.

______________________________ ______________________________
Resident Date

____
Print: Representative Name and Relationship

New Mexico Department of

SUPPORT DIVISION

REQUEST to HANDLE RECIPIENT'S FUNDS

NOTE: As a condition for participation in the New Mexico Medicaid Assistance Program each Skilled Nursing Facility (SNF) and Intermediate Care Facility (ICF) must establish and maintain an acceptable system of accounting for a recipient's personal funds when a Title XIX-Medicaid recipient requests that his personal funds be cared for by the facility. Form ISD 386 will be used by the facility to record in writing a recipient's request that the facility care or note care for his personal funds. A signed ISD 386 must appear in each facility Title XIX-Medicaid recipient file.

[X] I DO HEREBY REQUEST that FORT BAYARD MEDICAL CENTER facility assume the responsibility of holding and accounting for my personal funds $ ______________ and/or (list other items of value, if any): ____

____

____

____

____

I further request that the facility hold in trust for me the amount of my monthly personal needs allowance. I authorize the Administrator to expend in my behalf, when authorized by me or my representative, such monies in the facility's trust for items necessary for my personal needs and not provided as a covered service of this facility or by Title XIX-Medicaid.

[ ] I DO NOT REQUEST that FORT BAYARD MEDICAL CENTER facility assume the responsibility for my own personal funds, therefore, relieving the above named facility of any responsibility related to the holding or accounting for my personal funds.

RECIPIENT/REP. SIGNATURE	CASE NUMBER	DATE Mo | Dy | Yr
WITNESS NAME	ADDRESS	
WITNESS NAME	ADDRESS	