

**LAKEVIEW METHODIST HEALTH CARE CENTER**

610 Summit Drive

Fairmont, MN 56031

Phone: (507) 235-6606 ♥ Fax: (507) 235-3995

**RESIDENT BACKGROUND INFORMATION**

Name: \_\_\_\_\_  
Last First Middle Initial Preferred Name

Male  Female  Maiden Name: \_\_\_\_\_

Present or Hospital Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Permanent Home Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

How long have you lived at current address: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Marital Status: Single  Married  Widow  Widower  Divorced

Spouse's Name: \_\_\_\_\_

Who handles the bills and business mail? Is person Financial Power of Attorney?  Yes  No

Name Relationship Phone #: Home and Work

Address City State Zip Code

Who is Primary Responsible Party for Medical Information? Is person Health Care Power of Attorney?  Yes  No

Name Relationship Phone #: Home and Work

Address City State Zip Code

Do you have a court appointed conservator or guardian?  Yes  No

Name Phone #: Home and Work

Address City State Zip Code

Fairmont Physician's Name: \_\_\_\_\_ Alternate Physician's Name: \_\_\_\_\_

Pharmacy:  Sterling Drug  J& R Drug

Dentist: \_\_\_\_\_ Ophthalmologist or Optometrist: \_\_\_\_\_

Hearing Aid Specialist: \_\_\_\_\_ Podiatrist: \_\_\_\_\_

Funeral Home of Choice: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Church/Religion: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

Name of Pastor: \_\_\_\_\_ Phone # (\_\_\_\_) \_\_\_\_\_

**RELATIVES/ CHILDREN:**

Number of Children Total: \_\_\_\_\_ Male \_\_\_\_\_ Female

Name	Relationship	Phone #: Both Home and Work	
Address	City	State	Zip Code
Name	Relationship	Phone #: Both Home and Work	
Address	City	State	Zip Code
Name	Relationship	Phone #: Both Home and Work	
Address	City	State	Zip Code
Name	Relationship	Phone #: Both Home and Work	
Address	City	State	Zip Code
Name	Relationship	Phone #: Both Home and Work	
Address	City	State	Zip Code

If more space is needed, please add additional names on a separate sheet of paper and include with application.

**Social History:**

Resident's Former Occupation: \_\_\_\_\_ Date of Retirement: \_\_\_\_\_  
 Highest Level of School Completed: \_\_\_\_\_ Name of School: \_\_\_\_\_  
 Military Service: yes/no Branch: \_\_\_\_\_ VA Benefits: yes/no: \_\_\_\_\_

Have you ever been convicted of a crime?  yes  no Answering yes will not automatically disqualify you for admission.  
 If yes what was the crime you were convicted of? \_\_\_\_\_

Do you have a history of maltreatment?  yes  no Answering yes will not automatically disqualify you for admission.

List any prior stays in a nursing home, assisted living, board and care home, psychiatric setting, or MR/DD setting: \_\_\_\_\_

List any recent hospital stays: \_\_\_\_\_

**Lakeview Methodist Health Care Center Office Use Only:**

History & Physical Completed:  Yes  No  
 Date Completed: \_\_\_\_\_ Date Scheduled: \_\_\_\_\_

Pre-Authorization needed:  
 Yes  No Date of contact: \_\_\_\_\_  
 Name of contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Pre-Admission Screening:  
 30 Day Delay:  Yes  No If yes date to be called in by: \_\_\_\_\_  
 PAS called in by: \_\_\_\_\_ Date called in: \_\_\_\_\_  
 Verbal approval to admit:  Yes  No Date of contact: \_\_\_\_\_ Name of contact: \_\_\_\_\_

Name of County: \_\_\_\_\_ Date paper copy of PAS received: \_\_\_\_\_  
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610 Summit Drive  
Fairmont, MN 56031-2299  
Phone: (507) 235-6606

**RESIDENT INSURANCE BENEFITS INFORMATION**

**Name:** \_\_\_\_\_  
Last First Middle Initial

**Social Security Number:** \_\_\_\_\_ **Medicare Number:** \_\_\_\_\_ Part A  Part B

**Supplement Insurance through** \_\_\_\_\_  
(Insurance Company Name)

**Policy Number:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Insurance address/phone number:** \_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City State Zip Code Phone Number

**Medicare Part D through** \_\_\_\_\_  
(Insurance Company Name)

**Policy Number:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Insurance address/phone number:** \_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City State Zip Code Phone Number

**Medicare Replacement Plan through** \_\_\_\_\_  
(Insurance Company Name)

**Policy Number:** \_\_\_\_\_ **ID Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

**Insurance address/phone number:** \_\_\_\_\_  
Street Address  
\_\_\_\_\_  
City State Zip Code Phone Number

**Patient insurance co-pays and payment responsibilities vary with each insurance plan. Our Financial Services Department will call and verify your insurance benefits prior to admission.**

(Additional financial information needs to be completed on the reserve side of this form.)

Do you receive financial assistance such as: Medical Assistance, Elderly Waiver, Alternative Care or CADI:    Yes     No

Medical Assistance Number: \_\_\_\_\_ County: \_\_\_\_\_

Case Manager's Name: \_\_\_\_\_

Minnesota Senior Help Options plan: \_\_\_\_\_  
(Insurance Company Name)

Policy Number: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Insurance address/phone number: \_\_\_\_\_  
Street Address

City State Zip Code Phone Number

Income and Assets: \_\_\_\_\_

If assets total \$3,000 or less, please refer to Form DHS-2908:

*Medical Assistance Program Information for People:*

- *Living in a Nursing Home or*
- *Getting Elderly Waiver Services*

# Lakeview Methodist Health Care Center

## Social History

### Significant Data

Preferred Name: \_\_\_\_\_

Reason for admission: \_\_\_\_\_

Response to health concerns: \_\_\_\_\_

Concerns about placement: \_\_\_\_\_

Discharge goal: \_\_\_\_\_

Type of support system: \_\_\_\_\_

Reaction to placement:  Accepting  Unhappy  Angry  Resistant  Confused  Unaware of surroundings

Cognitive status:  Oriented  Forgetful  Confused  Disoriented to person  Disoriented to place  
 Disoriented to time

Communication Pattern:  No difficulties  Hard of Hearing  Written communication  Read lips  
 Speech impediment  Sign language or Braille  Language interpreter  Unable to communicate  
 Primary language not English  
 Other \_\_\_\_\_

Mood state:  Calm  Weepy  Angry  Depressed  Fearful  Irritable  Cooperative  Combative

### Previous Life Experiences

Birthplace: \_\_\_\_\_ Race/Ethnic Background \_\_\_\_\_

Primary language \_\_\_\_\_ Other languages spoken/understood \_\_\_\_\_

Military service: \_\_\_\_\_ Education: \_\_\_\_\_

Occupations and training (and dates) \_\_\_\_\_

Retirement date/reaction \_\_\_\_\_

Significant experience/achievements \_\_\_\_\_

Travel \_\_\_\_\_

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**Family and Significant Others**

Marital status \_\_\_\_\_ Marriage dates/divorce dates \_\_\_\_\_

Spouse's names \_\_\_\_\_ Age/or date of death \_\_\_\_\_

Children's names \_\_\_\_\_ Age/or date of death \_\_\_\_\_

Grandchildren \_\_\_\_\_

Significant others/any issues \_\_\_\_\_

Reaction to any losses \_\_\_\_\_

Responsibility/legal oversight \_\_\_\_\_

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**Religion/Spiritual**

Denomination \_\_\_\_\_ Church membership \_\_\_\_\_

Significance & involvement \_\_\_\_\_

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**Personal Interests**

Memberships in organizations (current/past) \_\_\_\_\_

Political interests/involvement (current/past) \_\_\_\_\_

**Substance use**

Tobacco products current \_\_\_\_\_

History \_\_\_\_\_

Alcohol current \_\_\_\_\_

History \_\_\_\_\_

Substance use current \_\_\_\_\_

History \_\_\_\_\_

**Mental Status**

History of MR/MI/DD \_\_\_\_\_

History of depression/anxiety \_\_\_\_\_

History of violent behavior/behavioral symptoms \_\_\_\_\_

**Personality**  Social/friendly  Quiet/shy  Introvert  Extrovert  Manipulative

Content/pleasant  Easily agitated  Lonely  Nervous  Further explanation

**Financial issues** \_\_\_\_\_

**Additional comments**

**Information obtained from** \_\_\_\_\_

Completed by: \_\_\_\_\_ Date: \_\_\_\_\_



# This is My Life

Name \_\_\_\_\_

Please share any personal information which will help us get to know you. This information helps us to individualize the care each person receives and will be shared with the direct care staff.

**Family:**

**Born/Places Lived:**

**Occupation:**

**I Enjoy:**

**Something I Would Like to Share about Me:**

# This is Important to Me

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

Please complete the following regarding your customary routine.

**Morning/AM Shift:**

**Afternoon/PM Shift:**

**Night Shift:**

**Likes:**

**Dislikes:**