Grover C. Dils Medical Center
700 N Spring Street
PO Box 1010
Caliente, NV 89008
Gcdmc.org

Dear Applicant,

Attached is the long-term care admission application and general information regarding services at Grover C. Dils Medical Center.

Please review and complete all forms prior to admission. This packet must be completed in its entirety before we can consider the applicant for long-term care admission.

We can help answer any of your questions by phone or in person. We will have you meet with our social services department to review the final application and any other necessary documents, prior to admission. You may call Social Services at 775-726-8027 for an appointment, Monday through Friday, 8:00 a.m. to 4:30 p.m.

We appreciate your interest in our facility and the possibility of taking care of your loved one.

Sincerely,

Tailor Rowe-Price, LMSW
Social Services Director
tailor@gcdmc.org
775-726-8027

Date Received: ________________________

Grover C. Dils Medical Center Long-term Care Application

PERSONAL INFORMATION

Applicants Full Name: ____ Phone Number: ___________________________

Address: ____

Street City State Zip Code

Date of Birth: _________ /_________ /_________ Sex: _______________ Social Security #: ________-______-________

Marital Status: ☐ Single ☐ Married ☐Widowed ☐ Divorced ☐ Separated

Spouse's Name: ____ ☐ Living ☐ Deceased ☐ Not Applicable

Mother's Maiden Name: ____

Hospital stay(s) during the past six months? ☐ Yes ☐ No Recent Discharge Date: _______________________________

If yes, name of Hospital: ____

Admitted from ☐ Home ☐ Hospital ☐Other Name of Facility: ____

Preferred Funeral Home: ____

INSURANCE INFORMATION

Medicare Name: ______________________________________ Medicare Number: _______________________________

Insurance: ____ ID Number: ___________________________________

Medicaid: ____ ID Number: ___________________________________

Long-term Care Insurance: _________________________________ ID Number: ___________________________________

REQUIRED PRIOR TO ADMISSION

1. Copies of applicant's insurance cards, social security card, etc.
2. A copy of legal guardianship or current power of attorney, advance directive or living will.
3. Copies of current bank statements.
4. An evaluation/clinic visit with one of our providers where you will need to receive a written recommendation to be admitted into long-term care at our facility.

FINANCIAL INFORMATION

Applicant's Source of Income:	Dollar Amount		
Retirement/Pension:	____________________	☐ Monthly	☐ Annually
Investment Income:	____________________	☐ Monthly	☐ Annually
Social Security (SSA):	____________________	☐ Monthly	☐ Annually
Supplemental (SSI):	____________________	☐ Monthly	☐ Annually
Veterans:	____________________	☐ Monthly	☐ Annually
Other:	____________________	☐ Monthly	☐ Annually

Assets:	Type/Location	Total Value/Balance
Real Estate:	____	____________________
Real Estate:	____	____________________
Personal Property:	____	____________________
Personal Property:	____	____________________

Bank Accounts:	Type/Location	Total Value/Balance
Checking:	____	____________________
Savings:	____	____________________
CD's:	____	____________________
IRA's:	____	____________________
401K/403B:	____	____________________
Other Accounts:	____	____________________
Insurance Policies:	____	____________________
Annuities/Cash Value:	____	____________________

Burial Fund? ☐ Yes ☐ No Irrevocable? ☐ Yes ☐ No

Applicant's Liabilities:	Dollar Amount		
Rent:	____________________	☐ Monthly	☐ Annually
Credit Cards:	____________________	☐ Monthly	☐ Annually
Insurance Premiums:	____________________	☐ Monthly	☐ Annually
Mortgage (Primary):	____________________	☐ Monthly	☐ Annually
Mortgage (Secondary):	____________________	☐ Monthly	☐ Annually
Alimony:	____________________	☐ Monthly	☐ Annually
Other:	____________________	☐ Monthly	☐ Annually

AUTHORIZED RESIDENT REPRESENTATIVE

(Person who will handle billing and/or sign papers)

Full Name: ____ Relationship: __________________________

Address: ____

Street City State Zip Code

Primary Phone: ___________________________________ Secondary Phone: _______________________________

Email: ____

Power of Attorney: ☐ Yes (Provide Copy) ☐ No **Court Appointed Guardian:** ☐ Yes (Provide Copy) ☐ No

NOTIFY IN CASE OF EMERGENCY

First Preference: _____________________________________ Relationship: ________________________________

Primary Phone: __________________________________ Secondary Phone: _______________________________

Secondary Preference: ________________________________ Relationship: ________________________________

Primary Phone: __________________________________ Secondary Phone: _______________________________

DECLARATION OF CONFIRMATION

I/We hereby confirm that all information stated in this document is current and correct to the best of my/our knowledge and no requested information has been withheld or misrepresented. I/We authorize Grover C. Dils Medical Center to verify any of the information above. I/We understand that falsification of the stated information may jeopardize admission at Grover C. Dils Medical Center. All information will be kept confidential by Grover C. Dils Medical Center, and will not be released without my written consent.

Signature: ____ Date: __________________________

Grover C. Dils Medical Center admits adult residents without regard to race, sex, age, religion or handicap. Admissions will be confined to applicants to whom the facility can safely and adequately provide care and services. Because of our rural setting, priority for admission will be given to our Lincoln County residents.

Grover C. Dils is a **non-smoking facility**.

A screening/authorization must be done prior to admission to assure the applicant needs nursing home care. If Medicaid will be your source of payment, A Medicaid application may need to be completed if you are not currently covered by Medicaid. Patient liabilities will need to be paid every month. If you are paying privately, payment in full is expected every month. **The cost of room, board and care is $330.00 per day**. Physical Therapy may be needed, and those charges are in addition to room and board. The facility will notify the applicants resident representative prior to starting those services. If ever there is an issue with payments, please contact Director of Business Services, April Nelson, at 775- 726-8011.

Your daily rate includes the following:

- 24-hour nursing care
- Oversight by a licensed physician
- Full-time dietary services
- Ongoing activities program
- Social services
- In-room telephone services
- Housekeeping services
- Maintenance services
- Laundry services
- Television/cable
- Necessary medical supplies

The following ancillary services are NOT covered in the daily rate:

- Beauty/barber shop services
- Personal comfort items
- Personal clothing
- Reading material
- Transportation
- Customized or specialized equipment
- Drugs billed by pharmacy
- Rehabilitative therapies
- Guest meals

Grover C. Dils will maintain a detailed accounting of all charges and deposits made to your resident fund account. Charges will only be made for services or items that were requested and provided. I have read and understand that the resident will be financially responsible for ancillary services detailed above.

____
Printed Resident Name

____
Facility Representative Name/Title

____
Resident/Resident Rep Signature

____
Facility Representative Signature

____
Date:

____
Date: