

New Athens Home for the Aged



203 SOUTH JOHNSON ST.
NEW ATHENS, ILLINOIS 62264
PHONE: 475-2550

Dear Potential Resident:

Beginning July 1, 1996, no citizen/resident of the State of Illinois can be admitted into this facility without first being pre-screened by an agent of the State of Illinois to determine the need for admission into this facility. This applies to all persons, regardless of the method of payment to the facility, including private paying individuals.

The agents for the State of Illinois who are responsible for the pre-screening are called Case Coordination Units funded by the Illinois Department on Aging. Before admission into this facility is possible, all potential residents must contact these agencies and arrange for a home visit by their staff to determine an individual's need for placement and nursing home services. (1-800-642-5429)

The pre-screening is conducted using a state form called a Determination of Need (DON). If the pre screening agent determines that you do not need nursing home placement, they will discuss with you other options. They cannot, however, stop you from entering this facility if you are paying privately. They can only require that you undergo the determination of need and pre-screening assessment.

There are many very straightforward and complicated issues regarding this new law of mandatory pre-screening of Illinois Citizens. If you are concerned about your rights, or if you have any questions or concerns, you should contact the Illinois Department on Aging in Springfield (1-800-252-8966) and/or your own local State Representative and Senator.

Sincerely,

Gary W. Holtgrewe
Administrator

NEW ATHENS HOME FOR THE AGED, INC.

203 S. Johnson Street
New Athens, IL 62264
(618) 475-2550

Entry Date _____

Application Date _____

Entry Number _____

Discharge Date _____

Name _____
Last Middle First

Last Residential Address _____

Name

Street

City

State

Zip Code

Birth Date _____ Phone No. _____

Marital Status _____ Name of Spouse _____

Place of Birth _____

Name of Sons Address Phone Number

Name of Daughters Address Phone Number

Name of Brothers Living or Deceased

Name of Sisters Living or Deceased

Religious Preference _____

A member of what church? _____ Address _____

Name of Pastor _____

What has been your trade or profession? _____

Educational Level: (circle one) None 1-8 9-11 High School Trade School
Some College Bachelor's Degree Graduate Degree

Language: (circle one) English Spanish French Other _____

Who is in charge of your financial affairs? (name and address) _____

Do you have a financial POA? If so, who? (name and address) _____

Medicare Number _____ Social Security No. _____

Medicare Part B: (circle one) Yes No

Do you receive Illinois Public Aid? _____ Amount _____

IPA No.: _____ Case ID No.: _____

If you do not receive Illinois Public Aid now, will it be necessary for you to apply for it when admitted to the Home? _____ Will it be necessary to apply for it in the future? _____ About when? _____

Have you disposed of property or possessions during the past 30 months? If so, give particulars: _____

What has been the state of your health? _____

Your mental status: (circle those that apply) Positive Negative Alert
Confused Passive Aggressive Other _____

If confused: (circle one) Mild Moderate Severe

Name of personal physician _____

How long has this physician cared for you? _____

When did you last consult your physician? _____

Are you aware of your medical diagnosis? _____ Please list _____

Condition of eyes? _____ Condition of hearing? _____

Date of your last tetanus shot _____

Have you had pneumonia vaccine? _____ If so, when? _____

Any know allergies? _____ If so, what? _____

Any difficulty in walking? _____ Use cane/walker? _____

Use wheelchair? _____ If so, will you supply your own? _____

Any difficulty with speech? _____

Who is your personal dentist? (name and phone no.) _____

Condition of teeth _____ Dentures? _____

Eating capabilities: (circle one) Feed self Need Assistance Must be fed

Do you have diabetes? (circle one) Yes No

If Yes, how controlled? (circle one) Diet Oral Medication Insulin

Bowel or Bladder Control: (0-10 mishaps per day?) _____

Confusion: (circle one) None Mild Moderate Severe

Funeral Director _____ Address & Phone No. _____

Do you have a Living Will? _____

Do you have a Health Care Power of Attorney or Guardianship? _____

If so, who? _____

Name _____ Phone Number _____

Street _____

City _____ State _____ Zip Code _____

Other advance directives: _____

Who shall be contacted in extreme illness? (Please list at least 2 & in order of Preference) Name Address Telephone

1.) _____

2.) _____

3.) _____