MARY HEALTH OF THE SICK
CONVALESCENT AND NURSING HOSPITAL
2929 Theresa Drive
Newbury Park, CA 91320
Telephone (805) 498-3644 FAX (805) 498-5112

Conducted by the Sisters Servants of Mary

Dear Applicant:

In order to be considered for admittance to Mary Health of the Sick, the following application forms must be completed in entirety.

- All applications will be kept on file for one year. In the fall of every year we update our waiting list and you will receive a letter inquiring if you still want to remain on the list.

- At that time, if you are on the "READY NOW" list and if there have been any changes in either the applicant's health or financial situation, please mark the appropriate box. If there have been changes, we will send you a copy of your previous application and a blank set of forms for you to update and return to us for inclusion in the applicant's file. If you are on the "NOT READY" list we will require an update at the time you become "READY NOW" and annually thereafter.

- In order to remain in the current pool of applicants, this notice must be returned to the Mary Health Business Office within 30 days. If we do not hear from you within this period of time, it will be assumed that Mary Health should no longer consider the individual a candidate for admission. In such a situation, the applicant's file will be removed from our waiting list and the application will be destroyed. Therefore, it is extremely important that you advise Mary Health during the year if you have a change in address, phone number or change in admission status. We will admit residents based on the information you provide. The admission status is very important. If you are not quite ready, please circle "not ready" this will not affect your place on the waiting list, as we always use your original application date. Your place on our waiting list remains constant and being on the "not ready" list simply means that we will not call you until we know that you are "ready now".

- Mary Health of the Sick has an approved Workforce shortage waiver from the California Department of Health Services.

We appreciate your cooperation. If you have any questions or would like to come for a tour, please feel free to call the front office. The office is open from 7:00am to 5:00pm Monday through Friday to schedule an appointment. Tours will be given on Wednesdays during scheduled hours only. We wish it were possible to serve everyone, but the hospital's capacity is limited and the needs of the community are immense.

Thank you for considering Mary Health of the Sick.

Resident/Resident Representative:_____Date:_____

MARY HEALTH OF THE SICK
CONVALESCENT AND NURSING HOSPITAL
PRE-ADMISSION INFORMATION PACKET

GENERAL INFORMATION

<table>
<tr><td colspan="2">Today's Date</td><td colspan="2">Original Application Date:</td><td>Admission Status</td></tr>
<tr><td colspan="3">Name of Applicant
☐ Ready Now
☐ Not Ready</td><td>Preferred Name:</td></tr>
<tr><td>Date of Birth</td><td>Place of Birth</td><td>U.S. Citizen?</td><td rowspan="8">Gender

Male:_____

Female:_____</td></tr>
<tr><td>Social Security Number</td><td>Medi-Cal/Medicaid Number</td><td>Marital Status (circle one)
1. Never married 4. Separated
2. Married 5. Divorced
3. Widowed</td></tr>
<tr><td>Medicare Number</td><td>Other Insurance</td><td>Method of Payment (circle one)
1. Private Pay (see note below)
2. Medi-Cal/Medicaid
3. Nursing Home Insurance
4. Other</td></tr>
<tr><td colspan="2">Current Residence</td><td>Type of Residence (circle one)
1. Private home 5. Acute care hospital
2. Private nursing 6. Psychiatric hospital
3. Assisted Living 7. Rehab. hospital
4. Nursing home 8. Other</td></tr>
<tr><td colspan="2">Current Doctor (name and phone number)</td><td>Mortuary Arrangements</td></tr>
<tr><td>Current Diagnosis</td><td>Height:
Weight:
Allergies:</td><td>Current Medications</td></tr>
<tr><td colspan="2">Resident Representative (name and address)</td><td>Phone
(h)
(w)
Cell

EMAIL:</td></tr>
<tr><td>Relationship to Applicant</td><td colspan="2">Do you have Power of Attorney for Health Care? Yes No
Do you have Advanced Directives? Yes No</td></tr>
</table>

Note: You are "Private Pay" if your income and assets will enable you to pay the monthly rate plus ancillaries without government assistance.

Facility Notes

MARY HEALTH OF THE SICK
CONVALESCENT AND NURSING HOSPITAL
PRE-ADMISSION INFORMATION PACKET

MEDICAL AND SOCIAL HISTORY

Current Mental Acuity (explain)	(Circle number if applicable) 1. Alert 2. Forgetful 3. Confused as to time 4. Confused as to place 5. Confused as to persons 6. Negative 7. Agitated/Anxious 8. Wanders 9. Depressed 10. Repetitive Verbalizations 11. Repetitive movements
Current Health Status	1. Continent 2. Incontinent 3. Partially continent 4. Catheter 1. Feeds Self 2. Needs help w/feeding 3. Special Diet 4. Feeding Tube 1. Stands by self 2. Stands w/ assist 3. Lifted manually 4. Lifted w/lifter 1. Ambulatory 2. Walks with assistance 3. Confined to wheelchair 4. Confined to bed 5. Requires bed rails 6. Uses walker or cane 1. Needs help w/bathing 2. Needs help w/dressing 3. Needs help w/grooming 1. Requires special equip. 2. Requires medical device(s)
Physical Handicaps	1. Vision 2. Hearing 3. Speech 4. Contractures
Past Medical History (operations, illnesses, etc.) and Family History (cancer, diabetes, etc.)	
Social History Number of children_____ Number of siblings_____ Current Interests_____ Past interests and hobbies_____	Religion_____ Primary Language_____ Former Occupation_____. Education (highest level completed)_____
Comments (if more space is needed please use separate sheet):	

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FINANCIAL INFORMATION

Note: The information requested on this page is required only if *payment method* is "private pay." If payment method is "Medi-Cal/Medicaid," this information is not required. The information below must reflect the assets and income available to pay for the resident's care while at Mary Health. As outlined by the Department of Health Services Standard Admission Agreement, **fraudulent misrepresentation of your finances to us, or failure to pay for the care you receive in this Facility are grounds for discharge.**

SUMMARY OF ASSETS AVAILABLE TO RESIDENT

Real Estate Personal Residence……. Other property……	$
Financial Assets Bank Account(s), Savings Accounts, Investment Accounts, Retirement Accounts etc.	$
Other Assets	$
TOTAL ASSSETS	$

ANNUAL INCOME AVAILABLE TO RESIDENT

Annual Social Security Income	$
Annual Pension Income	$
Annual Trust income	$
Other Annual Income	$
TOTAL ANNUAL INCOME	$

_____ _____
(Applicant) (Date)

_____ _____
(Responsible Party) (Date)

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Conducted by the Servants of Mary, Ministers to the Sick

MARY HEALTH
IS A NON SMOKING FACILITY

Smoke Free Policy According to state licensing regulations, a facility that is designated as "non-smoking" cannot admit individuals who will not agree to refrain from smoking inside the facility. This policy is designated to ensure that facilities do not violate a resident's right to self-determination under federal law, as specified in Sections 483.15(b) and 483.420 of Title 42 of the Code of Federal Regulations and as interpreted under the Federal Interpretive Guidelines. This Facility has been approved by the State Department of Health Services Licensing and Certification for program flexibility of Section 72507(b) for Skilled Nursing Facilities.

Waiver of Liability - Smoking

It is hereby acknowledged that the resident has been advised not to smoke while in the facility. The resident agrees to smoke only in designated outdoor areas and only under the direct supervision of an attendant employed by the facility. We do hereby agree that if the resident is injured or any property of the resident is damaged or destroyed by reason of smoking by the resident, the admitting facility shall not be liable for and is held harmless from all liability for such injury, damage or destruction. It is further agreed that the resident and responsible party shall be held liable for damage to hospital property and injury to others as a result of smoking by the resident.

If I am admitted to Mary Health of the Sick I agree to conform to the non-smoking policies of the facility.

_____ _____

Resident/ Resident Representative Signature Date