MINERS' COLFAX MEDICAL CENTER LONG TERM CARE

General Information

Date: ______________________

Name of Applicant: ______________________________

Address: ______________________________

____

Phone # ______________________________

Name of Person Completing Form: ____

Relationship to applicant: Family ☐ Friend ☐ Hospital/Nursing Home Staff ☐ Other ☐ ________________

Medical Provider: ______________________________

Emergency Contact: ______________________________ Telephone # ______________________
Cell Phone #______________________________

Where is the applicant currently residing? Home ☐ Hospital ☐ Nursing Home ☐ Other ☐____________

Demographics

Date of Birth: _____________ Age: _____________ SSN: _________________________

Miner ☐ Non-Miner ☐ Non Resident Miner ☐
(Please see LTC Admissions Policies)

Gender Male ☐ Female ☐

Marital Status
☐ Married
☐ Single
☐ Divorced or Widow

Race/Ethnicity
☐ Indian
☐ Asian
☐ Black
☐ Hispanic
☐ White

Lifetime Occupations: ____

____

Mining History:

	Mine	Occupation	Dates of Employment
1.	__________________	__________________	___________________________
2.	__________________	__________________	___________________________
3.	__________________	__________________	___________________________

Education Level: Circle highest grade completed: 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Applicant Name : ______________________ Date of Birth: ______________________

Payment Information

- ☐ Miners' Trust Beneficiary (Proof of mining employment and New Mexico residency required)
- ☐ Non-Miner/Self Pay
- ☐ Non-New Mexico Miner

Insurance Carrier ______________________

Policy # ______________________

Group # ______________________

Employer: ______________________

Subscriber Name: ______________________

Medical History

Have you been diagnosed or treated by a physician or health professional for any of the following conditions?

- ☐ Alcoholism
- ☐ Alzheimer
- ☐ Anemia
- ☐ Asthma
- ☐ Asthma
- ☐ Back Strain
- ☐ Black Lung Disease
- ☐ Bleeding Trait
- ☐ Bronchitis
- ☐ Cancer
- ☐ Cirrhosis
- ☐ Concussion
- ☐ Congenital defect
- ☐ Dementia
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Eye Problem
- ☐ Gout
- ☐ Hearing Loss
- ☐ Heart Problem
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Hyperlipidemia
- ☐ Kidney Problem
- ☐ Mental Illness
- ☐ Neck Strain
- ☐ Obesity
- ☐ Phlebitis
- ☐ Rheumatoid arthritis
- ☐ Stroke
- ☐ Thyroid problem
- ☐ Ulcer

Do you have an injury or illness that occurred while, or the result of, working in a mine? ☐ Yes ☐ No

If so, please describe the mine related illness, injury or disability: ______________________

____

Applicant Name: ______________________________ Date of Birth: ______________

Medications taken in the last six months:

1. ______________________ 6. ______________________
2. ______________________ 7. ______________________
3. ______________________ 8. ______________________
4. ______________________ 9. ______________________
5. ______________________ 10. ______________________

Do you have any of the symptoms?

- ☐ coughing up blood
- ☐ abdominal pain
- ☐ low back pain
- ☐ leg pain
- ☐ arm or shoulder pain
- ☐ chest pain
- ☐ swollen joints
- ☐ feeling faint
- ☐ dizziness
- ☐ breathless with slight exertion
- ☐ palpitation or fast heartbeat
- ☐ unusual fatigue with normal activity

Advanced Directives

Please list two individuals who will make medical decisions for you in the event that you are unable to do so. If you have a legal Power of Attorney, please attach the legal documents to the application.

Durable Power of Attorney for Healthcare ☐ Yes ☐ No

____

Legal Power of Attorney: ☐ Yes ☐ No

____

Primary Contact:

Name: ______________________

Relationship: ______________________

Address: ______________________

____

Phone: ______________________

Cell ______________________

e-mail: ______________________

Secondary Contact:

Name: ______________________

Relationship: ______________________

Address: ______________________

____

Phone: ______________________

Cell ______________________

e-mail: ______________________

Applicant Name: ______________________ Date of Birth: ______________________

Attestation

To be completed by applicant (if possible):

I ______________________, hereby submit my application and supporting
(Please Print Name)
documentation for consideration of eligibility for services provided at Miners' Colfax Medical

Center Long Term Care.

I am a legal resident of the State of New Mexico ☐ Yes ☐ No (Evidence of Residency 185 consecutive calendar days)

____

Applicant Signature

____

Date

Please complete if person completing application is someone other than the applicant:

I ______________________, hereby submit this application
(Please Print Name)

on behalf of ______________________ with permission and/or legal authorization given to
(Name of Applicant)
me by ______________________.
(Name of Person/Entity Granting Authority)

The applicant is a legal resident of the State of New Mexico ☐ Yes ☐ No

____

Signature

____

Date

Applicant Name: ______________________ DOB: ______________________

Pre-Admission Nursing Assessment

Person completing nursing assessment: ______________________ Date: ______________

Method used to conduct interview:

- ☐ Direct Contact (in person) Location of interview: ______________
- ☐ By telephone Person spoken to: ______________________
- ☐ Other please explain ______________________

Current Medical Diagnosis:

1. ______________
2. ______________
3. ______________
4. ______________
5. ______________
6. ______________
7. ______________
8. ______________

Code Status: Full ☐ DNR ☐ DNI ☐ Unknown ☐

Medications

Drug	Dose/Frequency	Drug	Dose/Frequency
1.		9.	
2.		10.	
3.		11.	
4.		12.	
5.		13.	
6.		14.	
7.		15.	
8.		16.	

Medication Allergies: Yes ☐ No ☐ If yes, list drug and applicant's reaction:

____

____

Applicant Name: ______________________ DOB: ________________

Activity Levels

	Independent	Needs Help	Dependent		Independent	Needs Help	Dependent
Walks	☐	☐	☐	In & Out of Chair	☐	☐	☐
Walker	☐	☐	☐	In & Out of bath	☐	☐	☐
Wheelchair	☐	☐	☐	Dresses Self	☐	☐	☐
In & Out of Bed	☐	☐	☐	Hygiene & Grooming	☐	☐	☐

Preference time of Bath____________________

Elimination

Bladder: ☐ Continent ☐ Incontinent ☐ Catheter

Bowel: ☐ Continent ☐ Incontinent ☐ Colostomy

night time voiding ______________ ☐ Frequent UTI's ☐ Dysuria ☐ Burning

Nutrition & Hydration

FOOD: ☐ Eats Well ☐ Needs Helps ☐ Difficulty Chewing ☐ Dentures ☐ Teeth

☐ Eats Poorly ☐ Needs Assistance ☐ Difficulty Swallowing

☐ Eats Independently ☐ Tube Fed Pump/Nutrition brands: ________________________

Special Diet: ____

Food Allergies: ____

Food Dislikes: ____

Food Preferences ____

Fluids: ☐ Drinks Well ☐ Needs Encouragement ☐ Will Not Drink

☐ Drinks Independently ☐ Needs Assistance ☐ Tube Hydrated

Fluid Preferences: ______________________________

Patterns

Daily Events:

Usually awake at _______ am/pm ☐ Naps during the day ☐ Goes out 1+ per week

Stays busy with hobbies ☐ Hobbies: ____________________

Drinks Alcohol ☐ Amount/Frequency: __________ Uses Tobacco ☐ Amount: ________

Daily/frequent contact with Family/Friends ☐ Who: ____________________

Up late at night ☐ Bedtime: __________

Attends church, temple or synagogue ☐ Involved in group activities ☐ Spends time alone ☐

Applicant Name: ______________________ DOB: ______________

Animal Companionship ☐ please describe: ______________________

	Normal	Impaired	Absent	Comments:
Speech	☐	☐	☐	________________
Sight	☐	☐	☐	________________
Hearing	☐	☐	☐	________________
Reading	☐	☐	☐	________________
Writing	☐	☐	☐	________________

Primary Language Spoken/Understood: ______________________________

Other Language(s) Spoken/Understood: ______________________________

Vitals

Temp: ________ Pulse: ________ Resp: ________ B/P ________ Weight: ______ Height: ______

Lung Sounds: ____

Oxygen Use: ______________________ Respiratory treatments: ______________________

Capillary Refill: ______________________ Cyanotic: Yes ☐ No ☐

Edema: Yes ☐ No ☐ Site: ______________________

General Skin Condition: ☐ reddened ☐ pale ☐ jaundice ☐ dry moist ☐ oily ☐

☐ warm ☐ cold ☐ bruises ☐ ulcers ☐ site: ______________________

Last Flu vaccination: ____________ PPD: ____________ Pneumovax ________ Tetnus: ________

Special Treatments and Procedure: ____

____

Attitudes & Behavior

- ☐ Alert
- ☐ Memory Good
- ☐ Quiet
- ☐ Depressed
- ☐ Uncooperative
- ☐ Memory Poor
- ☐ Strikes Out
- ☐ Calm
- ☐ Happy
- ☐ Sleeps Well
- ☐ Moody
- ☐ Combative
- ☐ Disoriented
- ☐ Cries Easily

- ☐ Oriented
- ☐ Easy to Excite
- ☐ Angers Easily
- ☐ Violent in past
- ☐ Unhappy
- ☐ Complains
- ☐ Outgoing
- ☐ Responsive
- ☐ Cooperative
- ☐ Withdrawn
- ☐ Hostile
- ☐ Runs Away
- ☐ Wakens Frequently
- ☐ Wanders at night

- ☐ Likes to be around other people
- ☐ Prefers to be by self
- ☐ Other: ________________

____

____

____

____

____

____

Applicant Name: ______________________ DOB: ______________

Admission Needs

Comments and Special Needs of Resident/Family:

____

____

____

Level of Care Required: ____________ Room Recommendation: ____________

Disclosure Statements required for this admission:

- ☐ Admission
- ☐ Fall Risk
- ☐ Pressure Sore
- ☐ Parkinson's
- ☐ Alzheimer's
- ☐ COPD
- ☐ Dementia
- ☐ Diabetes
- ☐ Osteoporosis
- ☐ Elopement Risk
- ☐ Comfort Care
- ☐ Amyotrophic Lateral Sclerosis
- ☐ Aspiration

Assessment completed by: ____________________________________
(Please Print Name)

Signature: ______________________________ Date: ______________

Applicant Name: ______________________________ DOB: __________________

Physical and Physical Examination Form

Application for admission to Miners' Colfax Medical Center Long Term Care

A documented history & physical from your medical provider must be completed and included with your application.
For your convenience, your medical provider may use this form to document your medical history and physical examination.

MEDICAL RECORD	REPORT OF MEDICAL HISTORY	Date of Exam

NOTE: This information is for official and medically-confidential use only and will not be released to unauthorized persons

1. NAME OF PATIENT *(Last, First, Middle)*			2. IDENTIFICATION NUMBER	3. GRADE
4a. HOME STREET ADDRESS			5. EXAMINING FACILITY	
4b. CITY	4c. STATE	4d. ZIP CODE		
6. PURPOSE OF EXAMINATION				

7. STATEMENT OF PATIENT'S PRESENT HEALTH AND MEDICATIONS CURRENTLY USED (USE ADDITIONAL PAGES IF NECESSARY)

a. PRESENT HEALTH	b. CURRENT MEDICATION	REGULAR OR INTERM.
c. ALLERGIES *(Include medications, insect bites/stings and common foods)*		
	d. HEIGHT	e. WEIGHT
8. PATIENT'S OCCUPATION	9. ARE YOU *(check one)* ☐ Right Handed ☐ Left Handed	

10. Past/Current Medical History

Check Each Item	Yes	No	Don't Know
Household contacts with anyone with tuberculosis			
Tuberculosis or positive TB test			
Blood in sputum or when coughing			
Excessive bleeding after injury or dental work			
Suicide attempts or plans			
Sleepwalking			
Wear corrective lenses			
Eye surgery to correct vision			
Lack vision in either eye			
Wear a hearing aid			
Stutter or stammer			
Wear a brace or back support			
Scarlet fever			
Rheumatic fever			
Swollen or painful joints			
Frequent or severe headaches			
Dizziness or fainting spells			
Eye trouble			
Hearing loss			
Recurrent ear infection			
Chronic or frequent colds			
Severe tooth or gum trouble			
Sinusitis			
Hay fever or allergic rhinitis			
Head injury			
Asthma			

Check Each Item	Yes	No	Don't Know
Shortness of breath			
Pain or pressure in chest			
Chronic cough			
Palpitation or pounding heart			
Heart trouble			
High or low blood pressure			
Cramps in your legs			
Frequent indigestion			
Stomach, liver, or intestinal trouble			
Gall bladder trouble or gall stones			
Jaundice or Hepatitis			
Broken bones			
Adverse reaction to medication			
Skin diseases			
Tumor, growth, cyst, cancer			
Hernia			
Hemorrhoids or rectal disease			
Frequent or painful urination			
Bed wetting since age 12			
Kidney stone or blood in urine			
Sugar or albumin in urine			
Sexually transmitted diseases			
Recent gain or loss of weight			
Eating disorder (anorexia, bulimia, etc.)			
Arthritis, Rheumatism, or Bursitis			
Thyroid trouble or goiter			

Check Each Item	Yes	No	Don't Know
Bone, joint or other deformity			
Loss of finger or toe			
Painful or "trick" shoulder or elbow			
Recurring back pain or any back injury			
"Trick" or locked knee			
Foot trouble			
Nerve injury			
Paralysis (including infantile)			
Epilepsy or seizure			
Car, train, sea, or air sickness			
Frequent trouble sleeping			
Depression or excessive worry			
Loss of memory or amnesia			
Nervous trouble of any sort			
Periods of unconsciousness			
Parent/sibling with diabetes, cancer, stroke, or heart disease			
X-Ray or other radiation therapy			
Chemotherapy			
Asbestos or toxic chemical exposure			
Plate, pin, or rod in any bone			
Easily fatigued			
Been told to cut down or criticized for alcohol use			
Used illegal substances			
Used tobacco			

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

PHYSICAL EXAMINATION

Date of Exam: ______________________
Height:_____________________________
Weight: ____________________________
Blood Pressure: ____________________
Pulse: _____________________________
Temperature: ______________________

INSTRUCTIONS – Describe (1) General appearance and mental status; (2) Head and neck (general); (3) Eyes; (4) Ears; (5) Nose; (6) Mouth; (7) Throat; (8) Teeth; (9) Chest (General); (10) Breast; (11) Lungs; (12) Cardiovascular; (13) Abdominal; (14) Hemmia; (15) Genitalia; (16) Pelvic; (17) Rectal; (18) Prostate; (19) Back; (20) Extremities; (21) Neurological; (22) Skin; (23) Lymphatics.

For miners, please document any mine related injury or illness.

IMPRESSION / ADMISSIONS DIAGNOSIS

SIGNATURE OF PHYSICIAN	NAME OF PHYSICIAN

Financial disclosure and arrangements are a vital part of the admission process and the reimbursement officer usually works with the applicant/interested party to admission so that an equitable reimbursement plan can be developed.

All applicants who are Medicaid recipients, or who have a Medicaid application pending must be reviewed prior to admission for level of care determination. Level of care will be determined by the members of the Admission Review Committee through review of documents provided with the admission packet. Meeting the requirements fir appropriate level of care does not automatically grant approval for admission to the facility as admission decisions are also based on appropriateness of available beds and units.

Miners' Colfax Medical Center
Long Term Care Facility
Services & Charges Summary

COST PER DAY: $ 404.55

28 Day Month $11,327.40
30 Day Month $12,136.50
31 Day Month $12,541.05

New Mexico Resident Miner: Cost per day for routine services are covered by Miners' Trust Fund

Non New Mexico Resident Miner: Cost per day for routine services are covered by Miners' Trust less calculated Miners' Medical Care Credit until 185 consecutive days of New Mexico residency are fulfilled

Non–Miner: $404.55 daily or Medicaid eligible based on prevailing Medicaid Reimbursement Rate

Costs of Routine Services: Allowable costs shall include all items of expenses that providers incur to provide routine services, known as operating costs. Operating costs include such things as:

(a) Regular room;
(b) Dietary and nursing services;
(c) Medical and surgical supplies (including syringes, catheters, ileostomy and colostomy supplies);
(d) Use of equipment and facilities;
(e) General services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas;
(f) Items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans;
(g) Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, Band-Aids, laxatives and fecal softeners, aspirin, antacids, OTC ointments and tongue depressors;
(h) Items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, and other durable equipment;
(i) Special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician;
(j) Laundry services including basic personal laundry.

Costs not covered by Miners' Colfax Long Term Care: The items listed below (including but not limited to) are the responsibility of the resident and are not covered at Miners Colfax Long Term Care.

(a) Physical Therapy
(b) Speech Therapy
(c) Occupational Therapy
(d) Dentist/Dentures
(e) Opthomologist/Optomistrist/ Eye glasses
(f) Audiologist/ Hearing Aides
(g) Podiatrist/ Footwear
(h) TV/Cable
(i) Phone
(j) Internet services
(k) Specialist care, e.g.; cardiologist, urologist, etc.
(l) Specialized equipment, e.g.; motor scooters, modified walkers or wheelchairs, etc.
(m) Ambulance services, including portion not paid for by other insurances
(n) Out of facility oxygen, medications and equipment
(o) Dialysis or other specialized treatment services
(p) Physician visits made at the physicians office
(q) Personal clothing
(r) Personal toiletries and grooming items e.g.: electric razors, toothbrushes, etc.
(s) Haircuts, beautician fees
(t) Transport services out of town for medical purposes
(u) Transport anywhere for non-medical related purposes that are not a planned activity
(v) Prescription medication
(w) Other outpatient services.

For additional information, contact Patient Accounting at 575-445-7725.

Reference:
Miners' Colfax Medical Center Policy-Establishing Charges at Miner' Colfax Medical Center Long Term Care Facility.

FINANCIAL AND PAYMENT CONTRACT

CONFIDENTIAL

Resident Name: ____________________________________ Social Security #: ____________________

Responsible Party:____

Address: ____

City: ______________________________ State: ____________________________ Zip: ___________

Home Phone: _____________________________ Work Phone: _________________________________

Amount of resident's monthly benefits: ____

Monthly allowable for personal trust account: ____

Monthly care and maintenance contract amount: ____

Payment plan: ____

____

I hereby authorize the Miners Colfax Medical Center Long Term Care to release medical and financial information as is necessary for processing my third party reimbursement claim to the parties identified, including, but not limited to, Social Security, Veterans, Railroad, Medicare, Medicaid, and/or public or private insurers.

I, the undersigned, hereby agree to pay the charges for treatment at the Miners Colfax Medical Center Long Term Care as per the above payment plan submitted to Federal and State Law and Regulations. These charges will be based on established rates for treatment services and as reduced by third party reimbursement, or provisions of Federal or State Law and Regulations. I understand Miners Colfax Medical Center Long Term Care does not have the authority to forgive debts owed to the State of New Mexico, and hereby authorize the acknowledgement of my account with the Miners Colfax Medical Center Long Term Care or to their designated credit and collection representative to allow for collection of delinquent accounts.

I, also agree that my financial commitment to the Miners Colfax Medical Center Long Term Care will be maintained on a monthly basis, and I understand that failure to comply may result in the discharge of the above mentioned resident, subject to and pursuant to all applicable Federal and State Laws and Regulations.

Resident/Responsible Party
Signature:____ Date: ______________

Print Name and
Relationship/Title: ____ Date: ______________

MCMC CFO or Designee____ Date _______________

Print/Sign and Title____

Miners' Colfax Medical Center Long Term Care
PATIENT FINANCIAL QUESTIONANAIRE

Patient Name: ______________________________ Social Security #: ______________

Date of Birth: ______________________________ Place of Birth ______________

Medicare Coverage ☐ Yes ☐ No Medicare Claim Number______________________
Part A Effective Date ______________________
Part B Effective Date______________________

Medicare D Coverage ☐Yes ☐No Medicare D Claim Number____________________
Prescription Drug Coverage Group Number ____________________

Medicaid Coverage ☐ Yes ☐ No Medicaid Number: ______________________

Health Insurance ☐ Yes ☐ No Provider Name: ______________________________
Policy Number______________________________
Group Number______________________________
Holder______________________________

PATIENT INCOME

Social Security Benefits: ____________________ Retirement Benefits: ______________
Civil Service Benefits: ____________________ Interest Income: ______________
Railroad Retirement Benefits: ________________ Dividends: ______________
Veterans Pension: ____________________ Rental Income: ______________
SSI Income: ____________________ Other Income: ______________
Property Owned: ____________________ Value Property: ______________
Checking Account____________________ Savings Account______________

EXPENSES

Rental Expenses: ____________________ Vehicle Payment: ______________
Mortgage Expenses: ____________________ Food Bill: ______________
Medical Bills: ____________________ Insurance Expenses: ______________
Utility Expenses: ____________________ Other Expenses: ______________

Life Insurance: ☐ Yes ☐ No Provider Name: ______________________________

Term Insurance _________ Whole Insurance____________ Irrevocably Assigned Policy____________
____

Value: ______________________________ Cash Value: ____________________

If you do not show any income for patient, what has been his/her means of support?

____

I, the undersigned applicant, responsible party, guardian, do hereby certify that the forgoing information is complete, true, and correct to the best of my knowledge. I also agree to provide documentation necessary for verification purposes.

Applicant Signature: ______________________________ Date: ______________

Print Name and Relationship/Title:________________________ Date: ______________

*MCMC reserves the right to request objective income verification documentation including but not limited to bank account statements, investment account statements, tax returns, etc.

Miners Colfax Medical Center Long Term Care

STATEMENT TO PERMIT PAYMENT OF MEDICARE/MEDICAID BENEFITS TO PROVIDER, PHYSICIAN AND RESIDENT

NAME OF RESIDENT: ____

SOCIAL SECURITY #: ____

I certify that the information given by me in applying for payment under Title 18 and Title 19 of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or related Medicare, Medicaid and private insurance claims.

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.

Resident/Responsible Party
Signature:____ Date: ______________

Print Name and
Relationship/Title: ____ Date: ______________