

# *Muskingum County Home*

*Rebecca J. Cooper  
Superintendent*

*Michael E. Moore, RN  
Administrative Nursing Coordinator  
Privacy Officer*

*Sophia Roberts, RN, BSN  
Administrative Nursing Coordinator  
Admission Director*

*Cathleen E. Matson  
Resident's Accounts*

## *Application for Residency*

**APPLICATION MUST BE FULLY COMPLETED (APPLICATION, PHYSICIAN'S STATEMENT, AUTHORIZATION FOR RELEASE OF MEDICAL/FINANCIAL INFORMATION) BEFORE POTENTIAL RESIDENT'S NAME WILL BE ENTERED ON MUSKINGUM COUNTY HOME WAITING LIST**

**PRIOR TO BEING ADMITTED TO THE MUSKINGUM COUNTY HOME**

**APPLICANT MUST HAVE POWER OF ATTORNEY WITH A MEDICAL CLAUSE/OR HAVE PREVIOUSLY COMPLETED ADVANCED DIRECTIVES, (LIVING WILL AND DURABLE POWER OF ATTORNEY). IF NEITHER OF THE ABOVE HAVE BEEN COMPLETED AND APPLICANT IS PRESENTLY INCOMPETENT THEN GUARDIANSHIP MUST BE OBTAINED PRIOR TO ADMISSION.**

**RESIDENT MUST HAVE CLEAR CHEST X-RAY WITHIN 1 YEAR OR 1ST TB TEST COMPLETE PRIOR TO ADMISSION**

**IF RESIDENT IS TO BE A PATIENT OF HOUSE DOCTORS (SOUTH ZANESVILLE FAMILY MEDICAL CENTER INC):**

**RESIDENT MUSK HAVE A COMPLETE PHYSICAL BEFORE ADMISSION AN APPOINTMENT TO HAVE THE PHYSICAL DONE AT THE OFFICE OF SOUTH ZANESVILLE FAMILY MEDICAL CENTER, INC WILL BE MADE BY THE MUSKINGUM COUNTY HOME NURSING STAFF**

**APPLICATIONS:**

**APPLICATIONS WILL REMAIN ON FILE SIX (6) MONTHS AFTER DATE OF RECEIPT. NEW APPLICATION MUST BE MADE AFTER THE SIX (6) MONTH PERIOD.**

**POTENTIAL RESIDENTS WHO ARE CONTACTED ABOUT ROOM AVAILABILITY BUT CHOOSE NOT TO BE ADMITTED AT THAT TIME WILL HAVE THEIR APPLICATION MOVED TO THE BOTTOM OF THE LIST**

**AT THE TIME OF ADMISSION YOU WILL NEED TO BRING:**

**MEDICARE CARD  
INSURANCE CARD (S)  
COPY OF POWER OF ATTORNEY/DURABLE POWER OF ATTORNEY FOR HEALTH CARE/LIVING WILL**

**ROOM & BOARD PAYMENT IS DUE UPON DAY OF ADMISSION AND IS PRORATED FOR THE MONTH**

**REBECCA J. COOPER  
SUPERINTENDENT**

MUSKINGUM COUNTY HOME APPLICATION  
FOR RESIDENCE

STATEMENT OF FACTS TO MUSKINGUM COUNTY HOME  
STATE OF OHIO, MUSKINGUM COUNTY

NAME OF TOWNSHIP OR MUNICIPALITY \_\_\_\_\_ DATE \_\_\_\_\_

**TO THE SUPERINTENDENT OF THE MUSKINGUM COUNTY HOME:**

NAME \_\_\_\_\_ AGE \_\_\_\_\_ SEX \_\_\_\_\_ RACE \_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

SOCIAL SECURITY # \_\_\_\_\_

MEDICARE # \_\_\_\_\_

MEDICAID # \_\_\_\_\_

PRESENT ADDRESS \_\_\_\_\_

PHONE # \_\_\_\_\_ LIVING ALONE? \_\_\_\_\_

U.S. CITIZEN? \_\_\_\_\_ LENGTH OF RESIDENCE IN OHIO \_\_\_\_\_ IN MUSKINGUM COUNTY \_\_\_\_\_

MARITAL STATUS \_\_\_\_\_ MILITARY SERVICE? YES \_\_\_\_\_ NO \_\_\_\_\_

RELIGION \_\_\_\_\_ NAME OF CHURCH \_\_\_\_\_

FORMER OCCUPATION \_\_\_\_\_ FORMER EMPLOYER \_\_\_\_\_

NAME OF FATHER \_\_\_\_\_ MAIDEN NAME OF MOTHER \_\_\_\_\_

**NAME, ADDRESS AND PHONE NUMBERS OF CHILDREN:**

NAME ADDRESS PHONE

NAME ADDRESS PHONE

NAME ADDRESS PHONE

**DOES APPLICANT HAVE POWER OF ATTORNEY WITH HEALTHCARE? \_\_\_YES \_\_\_NO**

NAME OF POWER OF ATTORNEY \_\_\_\_\_ PHONE \_\_\_\_\_

Muskingum County Home  
Financial Disclosure Statement

Resident: \_\_\_\_\_

Power of Attorney/Guardian: \_\_\_\_\_

ASSET

Savings Account: \_\_\_\_\_ Certificate of Deposit (CD): \_\_\_\_\_

Checking Account: \_\_\_\_\_ Credit Union: \_\_\_\_\_

Cash on Hand: \_\_\_\_\_ Trust Fund/Estate: \_\_\_\_\_

Individual Retirement Account: \_\_\_\_\_ Stocks: \_\_\_\_\_

Property (s): \_\_\_\_\_

List the value(s) of any property(s) transferred out of the above resident's name within the past 5 years.

INCOME

Disability or Sick Leave Benefits: \_\_\_\_\_ Dividends: \_\_\_\_\_

Estate or Trust Fund: \_\_\_\_\_ Railroad Retirement: \_\_\_\_\_

State, City, County Federal Employee's Retirement: \_\_\_\_\_ Supplement Security Income : \_\_\_\_\_

Union Funds or Pension Benefits: \_\_\_\_\_ Veteran's Benefits: \_\_\_\_\_

Worker's Compensation: \_\_\_\_\_ Lump Sum Payment: \_\_\_\_\_

**MEDICAL INFORMATION**

HAS APPLICANT BEEN ADMITTED TO ANY HOSPITAL WITHIN THE LAST 90 DAYS? \_\_YES \_\_NO

IF YES, NAME OF HOSPITAL AND DATES\_\_\_\_\_

IF NO, PLEASE LIST MOST RECENT HOSPITALIZATION\_\_\_\_\_

NAME OF PHYSICIAN\_\_\_\_\_

ADDRESS\_\_\_\_\_ PHONE\_\_\_\_\_

**INSURANCE INFORMATION**

DOES APPLICANT HAVE MEDICAL INSURANCE? \_\_\_\_\_

WHO WILL BE RESPONSIBLE FOR THE BILLS FOR THIS APPLICANT?

NAME\_\_\_\_\_

ADDRESS:\_\_\_\_\_

\_\_\_\_\_

PHONE\_\_\_\_\_

DOES APPLICANT HAVE PRE-PAID FUNERAL ARRANGEMENTS? \_\_\_\_\_

AT DEATH WHO WILL BE RESPONSIBLE FOR FUNERAL EXPENSES\_\_\_\_\_

NAME OF FUNERAL HOME\_\_\_\_\_

ADDRESS\_\_\_\_\_ PHONE\_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

***CONTACT PERSONS IN CASE OF DEATH OR SERIOUS ILLNESS:***

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

ADDRESS \_\_\_\_\_ PHONE \_\_\_\_\_

EMPLOYER \_\_\_\_\_ PHONE \_\_\_\_\_

I Hereby authorize my relatives, my physicians, or any other person, or bank, financial organization or Post Office having information concerning me personally, or concerning my circumstances, to furnish such information to the Superintendent of the Muskingum County Home or to his authorized representatives as they require in order to determine the need for my admission to, or my continued residence in the Muskingum County Home.

I understand and agree that any clothing or property in my possession are not to be given away without the consent of the Superintendent.

In case there is a balance after all bills are paid, the balance will go to the heirs or my estate.

I furthermore agree that I will abide by the laws of the State of Ohio, and the rules and regulations of the Muskingum County Home as prescribed by the Superintendent and the Muskingum County Commissioners.

I solemnly swear (or affirm) that the answers to the foregoing questions are full and true to the best of my knowledge and belief, and furthermore that I consent and agree to the above provisions and conditions of my admission to the Muskingum County Home. So help me God.

Signature of applicant \_\_\_\_\_

or

Signature of P.O.A. \_\_\_\_\_

or Guardian

**TO THE PHYSICIAN**

Has this patient ever been treated and/or hospitalized for a psychiatric disorder? \_\_\_\_\_ Yes \_\_\_\_\_ No

If patient is diagnosed as having Alzheimer's disease, at what stage is it? \_\_\_\_\_

*Patient is:*

Alert \_\_\_\_\_ Confused \_\_\_\_\_ Cheerful \_\_\_\_\_ Depressed \_\_\_\_\_ Combative \_\_\_\_\_ Uncooperative \_\_\_\_\_

**STATEMENT OF PHYSICIAN**

I hereby certify that I have personally examined \_\_\_\_\_

This \_\_\_\_\_ day of \_\_\_\_\_ 20\_\_\_\_\_, and do find him/her diagnosed with  
Date Month Year

\_\_\_\_\_  
\_\_\_\_\_.

I hereby certify that said \_\_\_\_\_ has *not been exposed to* any contagious or infectious disease at present.

I hereby certify that said \_\_\_\_\_ is *not suffering with* any contagious or infectious disease at present.

**The above resident may be admitted to the Muskingum County Home.**

**If patient wishes, I will continue care for this patient, as long as he/she is able to make office visits.**

\_\_\_\_\_  
Physician Signature **M.D.**      **Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**MUSKINGUM COUNTY HOME  
1400 NEWARK ROAD  
ZANESVILLE, OHIO 43701  
PHONE: (740) 454-8561  
FAX: (740) 454-6950**

**AUTHORIZATION FOR RELEASE OF  
MEDICAL/FINANCIAL INFORMATION**

**DATE:** \_\_\_\_\_ **RE:** \_\_\_\_\_

**DATE OF BIRTH:** \_\_\_\_\_ **MEDICARE#** \_\_\_\_\_

**SS#** \_\_\_\_\_

**Please furnish to the bearer, Muskingum County Home, or its representative, any and all information pertaining to my present and past medical and/or financial history. You further do have my permission to release copies of these records as may be requested by said Muskingum County Home.**

**A photo static copy of this authorization shall be considered same as original.**

**Signed:** \_\_\_\_\_  
**Resident or Responsible Party**