



Evergreen Community of Johnson County

Pre-Move In Information

This form is designed to help potential tenants and their families gather and compile the information necessary to move into a long term care community, such as Evergreen. Please fill this form out accurately and completely, and attach any additional information requested. If you need help during the process, please contact Evergreen's Life Transition Specialist, at 913.477.8227 or samanthav@ecojc.org with questions or to schedule an appointment to get further assistance.

Resident Information

First Name _____ Middle Initial _____ Last Name _____

Permanent Address _____

Current Location _____

Date of Birth _____ Age _____ Gender _____ Race _____ Veteran? _____

Birthplace _____ Marital Status _____ Religion _____

Primary Language _____ Education Level _____

Citizenship _____ Previous Occupation _____ SS# _____

Emergency Contact Information

Name _____ Relationship _____

Address _____

Cell Phone _____ E-mail Address _____

Home Phone _____ Work Phone _____

Additional Contact(s) Information

Name _____ Relationship _____

Address _____

Cell Phone _____ E-mail Address _____

Home Phone _____ Work Phone _____

Name _____ Relationship _____

Address _____

Cell Phone _____ E-mail Address _____

Home Phone _____ Work Phone _____



Payment Information

Please note our daily room rates: \$245/day for Semi-Private and \$265 for Private Rooms.

This section helps ensure that each individual has the means to pay for care. Each person must disclose financial information (along with corroborating paperwork). Evergreen has an obligation to determine if incoming residents meet the criteria for any state or federal funding. This process is similar in nature to a person divulging financial information to get a mortgage; Evergreen is, in effect, the individual's new home.

What is your expected payer source when moving in?

___ **Private Pay**

___ **KanCare (previously Medicaid)**

___ **LTC Insurance**

- Is the individual currently enrolled in Medicare (Part A or B) or KanCare or plan to apply? What MCO are they currently enrolled in? Does he/she have supplemental insurance?

- Does the individual receive Veterans Benefits, Railroad Retirement, SSI funds, or a private or government pension? What is the total amount of monthly income?

- What are the individual's assets, including cash, checking and savings accounts, stocks, bonds, CDs, trust funds, and real estate holdings?

- Does the individual have any paid-up life insurance policies or paid-up burial insurance or long-term care insurance?

- Has the individual transferred assets in the last 3-5 years?

- What is the individual's current living situation (rental housing, own a home)? What is the amount of the monthly rental or mortgage payment? Is he/she still paying utilities?

****Please provide copies of a photo ID and all insurance cards (front and back)****



Pertinent Medical Information

Major Diagnoses: _____

Has the individual had any recent hospitalizations? ____ Yes ____ No
If so, please list hospital, date(s), and admitting diagnosis: _____

Have you stayed in other rehab or LTC communities in the past 12 months? ____ Yes ____ No
If so, when and where? _____

Are you a smoker? ____ Yes ____ No Do you drink alcohol? ____ Yes ____ No
If you used to smoke, when did you quit? _____ If so, how much/often: _____

Are you currently receiving hospice services? ____ Yes ____ No
If so, which hospice company are you using: _____
Date of Admission: _____ Primary Diagnosis _____

Our Life Transition Specialist assists families through the move-in process, but it helps to be prepared. Evergreen requests the following additional information from your primary care physician (either in the community or at another long term care community). This information can either be personally obtained by you or your Durable Power of Attorney, or if a signed Information Release Form is on file, Evergreen can request the information.

- Face Sheet (Basic Information)
- History and Physical
- Current Physician's Orders (Treatments and Medications)
- Recent lab or X-Ray results, if applicable
- Last 6 months of their weight record
- Immunization Records i.e. Influenza, Pneumovax, and TB Skin Test
- Doctors', Nurses', Social Workers', and/or Therapy Progress Notes
- See Information Release Form (attached) for extended list of information to be requested



Advanced Directives

Have you currently named a family or friend to be your Durable Power of Attorney (DPOA) for Health Care? ____ Yes ____ No

If so, who? _____ Relationship _____

Additional Agents and Relationships: _____

Have you currently named a family or friend to be your Durable Power of Attorney for Finances? ____ Yes ____ No

If so, who? _____ Relationship _____

Additional Agents and Relationships: _____

Do you currently have a Living Will completed? ____ Yes ____ No

****Please provide copies of all DPOA and Living Will paperwork. If you have not appointed a DPOA for health care/finances or completed a Living Will, the Quality of Life Department at Evergreen can help you do so.****

CARE Assessment

A CARE (Client Assessment, Referral, and Evaluation) Assessment must be completed by the state of Kansas prior to moving into any Medicaid accepting long term care community, such as Evergreen. These must be requested through the local Kansas Aging and Disability Resource Center at 913.715.8820.

Do you have a CARE Assessment completed? ____ Yes ____ No

- If yes, when? Date of completion: _____

****Please provide a copy of CARE Assessment**

- If no, has one been requested? ____ Yes ____ No
 - If yes, when? Date of request: _____

Additional Information: _____

Please Fax, Mail, or Drop Off to:

Evergreen Community Attn: Samantha Vongchantha

11875 S. Sunset Drive, Suite 100, Olathe, KS, 66061

Phone 913.447.8272 Fax 913.477.8001



AUTHORIZATION TO RELEASE INFORMATION

Name: _____

D.O.B.: _____ Social Security #: _____

Name of Institution Holding Records: _____

Phone Number: _____

Fax Number: _____

I authorize you to release records to Evergreen Community of Johnson County, (11875 S. Sunset Drive, Suite 100, Olathe, KS, 66061) for the purposes of assessment and admission.

****This information may be faxed to ECOJC at (913)477-8005.****

Please release the following portion(s) of the individual's medical record:

- | | |
|--|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Physical Therapy Eval & notes |
| <input type="checkbox"/> History & Physical | <input type="checkbox"/> Occupational Therapy Eval & notes |
| <input type="checkbox"/> CARE Assessment/PASRR | <input type="checkbox"/> Speech Therapy Eval & notes |
| <input type="checkbox"/> Operative Report(s) | <input type="checkbox"/> Lab/Diagnostic Testing Report(s) |
| <input type="checkbox"/> Progress notes | <input type="checkbox"/> Advanced Directives |
| <input type="checkbox"/> Physicians Orders | <input type="checkbox"/> Immunization Records |
| <input type="checkbox"/> Medication Records | <input type="checkbox"/> Psychiatric/ Behavioral Health records |
| <input type="checkbox"/> Other _____ | |

This authorization will remain in effect for thirty (30) days, at which time the consent will expire unless revoked earlier. This authorization can be revoked in writing by the individual at any time, but is NOT retroactive to the release of information made in good faith. By signing this authorization, the undersigned agrees NOT to disclose as expressly permitted by necessary implication inherent in the purpose of the original consent or authorization.

PROPOSED NEW USE OF INFORMATION WITHOUT ADDITIONAL WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS IS PROHIBITED.

The undersigned hereby releases the above mentioned institution from any liability which may arise from release and/or examination of the information indicated above.

Signed: _____
(Name or representative)

Date: _____

Witness: _____

Date: _____