Meadow Brook Medical Care Facility
4543 South M-88 HWY | Bellaire, MI 49615
Admissions P. 231-533-8661 ext 115 | F. 231-533-5841

Meadow Brook
Antrim County Medical Care Facility

PRE-ADMISSION APPLICATION

APPLICANT INFORMATION	
Full Legal Name:	
Date of Birth:	County of Residence:
Phone Number:	Alternate Number:
Current Address:	
Email Address:	

INSURANCE AND LEGAL INFORMATION		
Social Security #:	Medicare #:	Medicaid #:
Supplemental:	Other Insurance:	Long Term Care Insurance:
Veteran? ☐ ☐	If yes, file #:	Branch of Service:
If a current or former spouse of a Veteran, file #:		
If a widow of a Veteran, file #:		
Will you be applying for Medicaid?		
Does the applicant have any of the following: Legal Guardian ☐ Conservator ☐ DPOA Medical ☐ DPOA Financial ☐ None ☐		
Where is the applicant currently living?		
Any prior hospital or nursing home stay? **Yes** ☐ **No** ☐		
If yes, where and what dates?		
Is the resident receiving care through Hospice? **Yes** ☐ **No** ☐		
If yes, name of hospice and phone number:		

THIS APPLICATION IS VALID FOR 60 DAYS UPON RECEIPT

RESPONSIBLE PARTY	
Name:	Relationship:
Address:	
Phone Number:	Alternate Phone:
Email Address:	
Preferred Method of Contact: Cell Phone ☐ Email ☐	

NOTICE!

COPIES OF THE FOLLOWING MUST BE RETURNED WITH THE PRE-ADMISSION PACKET:

- ❑ SOCIAL SECURITY CARD
- ❑ INSURANCE CARDS
- ❑ VETERAN'S DISCHARGE PAPERS (IF ANY)
- ❑ GUARDIANSHIP PAPERS (IF ANY)
- ❑ DPOA FINANCIAL/MEDICAL (IF ANY)
- ❑ PATIENT ADVOCATE (IF ANY)
- ❑ CONSERVATORSHIP (IF ANY)

FROM YOUR PHYSICIAN:

- ❑ HISTORY AND PHYSICAL (COMPLETED IN THE LAST 3 MONTHS)
- ❑ LIST OF CURRENT MEDICATIONS AND DOSAGES
- ❑ DSS 3877 AND 3878 (INCLUDED IN PRE-ADMISSION PACKET)

Please call Meadow Brook Admissions if you have any questions at:

231-533-8661 ext. 115

Please return the completed Pre-Admission Application to:

Meadow Brook Medical Care Facility – Admissions

4543 South M-88 HWY Bellaire, MI 49615

admissions@meadowbrookmcf.com

Fax – 231-533-5841

Applications can be hand-delivered, emailed or faxed to the information provided above.

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PRE-ADMISSION APPLICATION – RESIDENT HISTORY

To provide personalized care to each resident, understanding their background, daily routines and preferences is crucial. This knowledge is particularly valuable when creating a plan of care. Please complete this questionnaire to the best of your ability to assist us in meeting your loved one's needs.

Personal Information

Resident Name:_____ Maiden Name:_____

D.O.B:_____ Place of Birth:_____

Parent's Names:
Mother_____Father_____

Are parents living or deceased?_____

Sibling Names? Are they living or deceased?_____

_____

Spouse Name? Are they living or deceased?_____

Date of Marriage:_____ Prior Marriages:_____

Children? If so, name/age/where they live:_____

_____

Former Occupation:_____ Year retired/last worked:_____

Did they do shift work?_____

Religion of Choice:_____ Church attended?_____

Funeral Home of Choice:_____

**If no choice is listed above, we default to Mortensen Funeral Home until notified of other choice.

Clinical Information

Has resident ever received mental health services? Inpatient or outpatient? _____

Location and when?_____

Is there any past substance addiction (alcohol, tobacco, recreational drugs, etc.)? YES ☐ NO ☐

If yes, please explain:_____

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Any history of past physical, emotional or sexual abuse that you are aware of? YES ☐ NO ☐

If yes, please explain (or talk directly to the unit Social Worker when admitted):_____

_____

Any past traumatic events i.e.; war, unexpected death of loved one, house fire or serious car accident?

YES ☐ NO ☐ If yes, please explain:_____

_____

Are there any behavioral issues?_____

_____

Aggression towards others? YES ☐ NO ☐ If yes, please explain:_____

_____

History of wandering? YES ☐ NO ☐

Daily Routine

Usual rising time:_____ Usual bedtime:_____

Specific food dislikes?_____

Do they prefer shower or bath?_____ Do they prefer AM/PM?_____

Is there any specific TV programming they watch daily?_____

Do they wear hearing aids?_____ Right/Left/Both?_____

If no, when was their last hearing appointment and with who?_____

Do they wear dentures?_____ Upper/Lower/Partial Upper/Partial Lower?_____

If no, when was their last dentist appointment?_____ Name of Dentist:_____

Is there anything else that you would like to share that would help with caring for your loved one?

Signature of person completing:_____Date:_____

Phone number that we can reach you at:_____

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