

# DELTA REHAB AND CARE CENTER

## Admission Packet Checklist

**Patient Name:** PARVIN, MARY

**Admit Date:** 5/22/12

**IDENTIFY FINANCE CLASS:**

**PRIMARY:** ☒ Medicare A ☐ Private ☐ Medi-Cal ☐ Other

**SECONDARY:** ☐ Private ☐ Medi-Cal ☒ Other MUTUAL OF OMAHA

Identify if patient has a private insurance which will cover all or part of charges, including coinsurance, and identify if facility will bill the insurance for the patient.

**Other third party:** \_\_\_\_\_

**Business Office Audit**      **Admission Audit**

**A. COMPLETE FOR ALL ADMISSIONS:**

- |     |     |   |   |
|-----|-----|---|---|
| ___ | 1.  | <input checked="" type="checkbox"/> 1.  | Admission Agreement (58 pages) (See Page 58 for Checklist)                        |
| ___ | 2.  | <input checked="" type="checkbox"/> 2.  | Face Sheet (Point Click Care)   |
| ___ | 3.  | <input checked="" type="checkbox"/> 3.  | Medicare Secondary Payor Questionnaire  |
| ___ | 4.  | <input checked="" type="checkbox"/> 4.  | Financial Planning  |
| ___ | 5.  | <input checked="" type="checkbox"/> 5.  | Skilled Nursing Facility Advance Beneficiary Notice (SNFABN) (CMS-10055)          |
| ___ | 6.  | <input checked="" type="checkbox"/> 6.  | Appointment of Representative (SSA-1696-U4)                                       |
| ___ | 7.  | <input checked="" type="checkbox"/> 7.  | Assignment of Benefits  |
| ___ | 8.  | <input checked="" type="checkbox"/> 8.  | Medical Records Release (fax to hospital) - <i>Route to Medical Records Dept.</i> |
| ___ | 9.  | <input checked="" type="checkbox"/> 9.  | Advance Directives – POLST ( <i>Place in Patient Chart</i> )                      |
| ___ | 10. | <input checked="" type="checkbox"/> 10. | Ancillary Agreements  |
|     |     | ___ a.                                  | Pharmacy  |
|     |     | ___ c.                                  | Podiatry  |
|     |     | ___ b.                                  | Optometry   |
|     |     | ___ c.                                  | Dental  |
| ___ | 11. | <input checked="" type="checkbox"/> 11. | Prior Stay Worksheet – <i>Route to DNS and Medical Records</i>                    |
| ___ | 12. | <input checked="" type="checkbox"/> 12. | Insurance Verification/Authorization Form   |
| ___ | 13. | <input checked="" type="checkbox"/> 13. | Medi-Cal Pending Eligibility Log – <i>Business Office route to Social Service</i> |
| ___ | 14. | <input checked="" type="checkbox"/> 14. | LTC Facility Information Sheet for Public Assistance (MC 171)                     |
| ___ | 15. | <input checked="" type="checkbox"/> 15. | Bed Hold Acknowledgment   |
| ___ | 16. | <input checked="" type="checkbox"/> 16. | Notification of Transfer/Release – Bed Hold (Complete upon Transfer/Discharge)    |
| ___ | 17. | <input checked="" type="checkbox"/> 17. | Informed Consent Policy (Psychotherapeutic Meds)                                  |
| ___ | 18. | <input checked="" type="checkbox"/> 18. | Permission to Inform Select Persons   |
| ___ | 19. | <input checked="" type="checkbox"/> 19. | Medi-Cal General Property Limitations (MC 007)                                    |

Photocopy the following items:

- |     |    |  |  |
|-----|----|--|--|
| ___ | 1. | <input checked="" type="checkbox"/> 1. | Medicare Card – specify coverage available: <input type="checkbox"/> Part A <input type="checkbox"/> Part B<br>If card is not available, document verification of coverage with Social Security; copy of Common Working File |
| ___ | 2. | <input checked="" type="checkbox"/> 2. | Medi-Cal Card  |
| ___ | 3. | <input checked="" type="checkbox"/> 3. | Proof of legal representation (___ conservator, ___ legal guardian, ___ Power of Attorney (POA), ___ Durable Power of Attorney (DPOA))   |
| ___ | 4. | <input checked="" type="checkbox"/> 4. | Private Insurance Cards (document what coverage is available)  |
| ___ | 5. | <input checked="" type="checkbox"/> 5. | Transfer Sheet (from hospital and/or prior facility)   |