

St. Paul's John A. McColl Family Health Center

Skilled Nursing

235 Nutmeg Street
San Diego, CA 92103

For information call:

(619) 239-6900

Fax (619) 236-0034

www.stpaulseniors.org



St. Paul's
Senior Homes & Services
A Full Service Retirement Community

328 Maple Street
San Diego, CA 92103
Phone (619) 239-6900 Fax (619) 236-0034



John A. McColl Family Health Center
License Number: 080000181



SKILLED NURSING CARE

JOHN A. McCOLL FAMILY HEALTH CENTER is a Skilled Nursing Community where the skilled level of care is often referred to as “convalescent care.” Skilled nursing care is designed for the individual who requires 24-hour supervision and frequent assistance to accomplish minimal “Activities of Daily Living” (ADL’s) and who may be confined to a wheelchair or bed.

TEAM NURSING AT JOHN A. McCOLL FAMILY HEALTH CENTER

JOHN A. McCOLL FAMILY HEALTH CENTER provides 24-hour nursing services by licensed staff, seven days a week. Upon admission to the Health Center, the resident is introduced to the Charge Nurse who is responsible for coordinating the resident’s care. Conferences, referrals, transfers and other services which are provided by nursing, personnel, physicians, and family members to meet the changing needs of the resident, are also coordinated by the Charge Nurse.

**Room and Board Rates Per Day
Effective September 1, 2011**

Rooms:	3 beds	\$196.00
	2 beds	\$219.00
	Private	\$361.00

The above rates are subject to change upon thirty (30) days written notice. The above rates include:

1. Three meals per day in the dining room or tray service, plus snacks order.
2. Daily assistance with “Activities of Living,”(i.e., dressing, bathing, ambulation, personal hygiene, and needs).
3. Daily housekeeping service.
4. Dispensing of medication as prescribed by physician.
5. 24-hour supervision and service by licensed personnel (Registered Nurses, Licensed Vocational Nurses, and Certified Nursing Assistants).
6. Planned recreational and occupational therapy programs.
7. Furnished rooms, including bed, chair, wardrobe, night stand, over bed table and bulletin boards.
8. Facilities for physical therapy.
9. Facilities for barber and beauty shop service.
10. Support group meetings.
11. Activities program.



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Ph: (619) 239-8687 Fax: (619) 239-1201
Lic. # 080000181

APPLICATION FOR RESIDENCY

NAME _____ DATE OF BIRTH _____ AGE _____

PRESENT ADDRESS _____ TELEPHONE _____

CITY _____ ST _____ ZIP _____

MARITAL STATUS: Married Widowed Divorced Single

SOCIAL SECURITY NUMBER _____ MEDICARE NUMBER _____

OTHER INSURANCE _____

NAME OF INSURANCE COMPANY _____

PLACE OF BIRTH _____ CITIZENSHIP _____

FATHER'S LAST NAME _____

MOTHER'S MAIDEN NAME _____

PREVIOUS OCCUPATION _____

RELIGIOUS DENOMINATION _____ Active Inactive

PLACE OF WORSHIP OR MINISTER'S NAME _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

NAME OF FACILITY ADMITTED FROM _____

DATE OF ADMISSION _____

REQUEST ADMISSION BY THE FOLLOWING DATE _____

PRIVATE PAY ACCOMMODATIONS: Private Double room Triple room

NAME(S) AND COMPLETE ADDRESS OF ATTENDING PHYSICIAN

PHYSICIAN _____ TELEPHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

ALTERNATE PHYSICIAN

PHYSICIAN _____ TELEPHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

DENTIST _____ TELEPHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

PHARMACY _____ TELEPHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

HOW DID YOU FIRST LEARN OF THE JOHN A. McCOLL FAMILY HEALTH CENTER?

Newspaper or other Advertisement (Please specify name): _____

Yellow Pages

Church Church Name: _____

Church Address: _____

Ministers Name: _____

Open House (Date): _____

Physician (Name): _____

Current Resident: _____

Family Member (Relationship and name): _____

Friend (Name): _____

Other (Please explain): _____

LEGAL/RESPONSIBLE (GUARANTOR) PERSON

NAME _____ RELATIONSHIP _____
ADDRESS _____ WORK PHONE _____
CITY/ST _____ ZIP _____ HOME PHONE _____

PERSON(S) TO NOTIFY IN CASE OF EMERGENCY

NAME _____ RELATIONSHIP _____
ADDRESS _____ WORK PHONE _____
CITY/ST _____ ZIP _____ HOME PHONE _____

NAME _____ RELATIONSHIP _____
ADDRESS _____ WORK PHONE _____
CITY/ST _____ ZIP _____ HOME PHONE _____

BILLING DATA

Please check the following services desired. A charge will be added to your monthly bill. Laundry and incontinence fees are not optional.

	<u>Yes</u>	<u>No</u>
Wheelchair rental	<input type="checkbox"/>	<input type="checkbox"/>
Geriatric chair rental	<input type="checkbox"/>	<input type="checkbox"/>
Television rental	<input type="checkbox"/>	<input type="checkbox"/>
Trust account	<input type="checkbox"/>	<input type="checkbox"/>
Beauty Shop	<input type="checkbox"/>	<input type="checkbox"/>
Billed to you directly	<input type="checkbox"/>	<input type="checkbox"/>

There is a minimum two week charge for equipment rentals.

BILL TO:

NAME _____ TELEPHONE _____
ADDRESS _____ CITY _____ ST _____ ZIP _____

INTERMENT PLANS

MORTUARY NAME _____ TELEPHONE _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

LEGAL DOCUMENTATION

The following documents are recommended to be on file for all residents of the Health Center. Please review and provide the following:

1. Durable Power of Attorney for Health Care YES NO
2. Conservator Information YES NO

If yes:

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (_____) _____

3. Directive to Physician YES NO
4. Power of Attorney (fiduciary) YES NO
5. Living Will YES NO

Please return this form along with the Financial Disclosure Form and other requested documents to:

John A. McColl Family Health Center

Admissions Department
235 Nutmeg Street
San Diego, CA 92103





Financial Disclosure to St. Paul's Senior Homes & Services



St. Paul's Senior Homes & Services (St. Paul's) respects the privacy of every applicant and does not desire to intrude into any applicant's personal financial circumstances other than to have assurance that the necessary amounts needed to provide for the applicant's extended lodging, food, health care and personal needs are available to the potential resident.

The applicant and/or responsible party understands that St. Paul's will rely on the financial information regarding the applicant's assets, liabilities, income and expenses in making its determination as to whether the applicant will be admitted to St. Paul's facilities and that St. Paul's would not admit the resident to the facilities but for the accuracy and truthfulness of such information. The applicant and/or responsible party understands that the resident may be discharged by St. Paul's if it discovers that any such information has been misrepresented or omitted by the resident/responsible party, regardless of whether such misrepresentation or omission could have been discovered earlier by St. Paul's.

Financial Statement

Applicant's Full Name _____ Social Security # _____

Income & Expenses:

Monthly Income -

Social security	\$ _____
Pensions	\$ _____
Annuities (____ (X) lifetime or ____ years ending _____)	\$ _____
Interest income	\$ _____
Dividends	\$ _____
Rental income	\$ _____
Other income (_____)	\$ _____
(_____)	\$ _____

Monthly Expenses -

Health insurance	\$ _____
Other household & personal expenses	\$ _____

Assets -

Bank - checking	\$ _____
savings/CDs	\$ _____
Broker - money market funds	\$ _____
fixed income securities (bonds, preferred stocks)	\$ _____
equities (stocks)	\$ _____
Real estate - residence (net of any outstanding loans)	\$ _____
other (vacation home/rentals) (net)	\$ _____
Other assets - (_____)	\$ _____

I DECLARE UNDER PENALTY OF PERJURY that the foregoing financial information is a **true statement** of facts known by me, and that it is submitted as part of an application for residency at St. Paul's facilities. I also declare that all of the above assets are **available to the Applicant to provide for the future needs of the Applicant**, and that **none of the assets will be transferred to another individual or individuals to avoid liability** for those needs.

Date Applicant for Residency *or* Date Financially Responsible Party