ST. PAUL'S SENIOR SERVICES

EQUAL HOUSING OPPORTUNITY

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, 2019– August 31, 2020

Room:	3 beds	$291
	2 beds	$322
	Private	$549

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.

St. Paul's
SENIOR SERVICES

John A McColl Family Health Center
Skilled Nursing
235 Nutmeg Street
San Diego, CA 92103
Ph: (619) 239-8687 Fax: (619) 677-3895
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 _____

NAME OF FACILITIY 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.

	Yes	No
Wheelchair rental	☐	☐
Geriatric chair rental	☐	☐
Trust account	☐	☐
Beauty Shop	☐	☐
Billed to you directly	☐	☐

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

EQUAL HOUSING OPPORTUNITY

Financial Disclosure to St. Paul's Senior Services

St. Paul's Senior 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 misrepresentations or omission could have been discovered earlier by St. Paul's.

Financial Statement

Applicant Name: _____ Social Security #: _____

Monthly Income:

Social Security	$_____
Pensions	$_____
Interest Income	$_____
Annuity (lifetime_____or years ending_____)	$_____
Trust (Name_____)	$_____
Family Support	$_____
VA Aid & Attendance	$_____
Long Term Care Policy (lifetime____or cap____)	$_____
Other:_____	$_____

Monthly Expenses:

Health Insurance	$_____
Prescriptions, medical expenses	$_____
Living expenses	$_____
Auto/mortgage/rent (continuing)	$_____
Other:_____	$_____

Current Assets:

Checking Account	$_____
Savings Account	$_____
Stocks/Bonds (currently accessible?)	$_____
Trust (Name_____)	$_____
401K (penalty for withdraw?)	$_____
Real Estate – residence	$_____
other (vacation/rental)	$_____
Other:_____	$_____

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.

_____ _____ OR_____ _____

Date Applicant for Residency Date Financially Responsible Party