INOVA®
Loudoun Nursing and Rehabilitation Center

Dear Applicant:

Attached is Inova Loudoun Nursing and Rehabilitation Center's basic Long Term Care admission application and general information regarding services at our facility.

Please review this information carefully and complete all forms prior to returning them to ILNRC. This entire packet must be returned to us before we can consider the applicant for a Long Term Care admission.

We will be happy to answer any of your questions by phone or in person. We encourage applicants and family members to visit our facility as part of the application process. You may call for an appointment, Monday through Friday, 8:00 a.m. to 4:30 p.m.

Thank for your interest in our facility.

Sincerely,

Pamela S. Janney, BSN, RN, LNHA,
Administrator 703-771-2841

LOUDOUN NURSING AND REHABILITATION CENTER

APPLICATION

Date received: _____

PERSONAL INFORMATION

Applicant's Full Name _____Phone Number _____

Address _____ City _____ State _____ Zip _____

Date of Birth ____/____/_____ Age _____ Sex_____ Soc. Security No. _____

Marital Status ❑Single ❑Married ❑Widowed ❑Divorced ❑Separated

Spouse's Name _____❑ Living ❑Deceased

Mother's Maiden Name_____

Hospital stay(s) during the past 6 months? ❑ Yes ❑ No Name of Hospital(s) _____

Hospital discharge date(s) _____ and _____

Have you been in a Medicare certified nursing home bed in the past year? ❑ Yes ❑ No

If yes, Name of Healthcare Center _____

If yes, Admission date_____

Preferred Funeral Home: _____

AUTHORIZED RESIDENT REPRESENTATIVE

(Person who will handle billing and / or sign papers)

1. Full Name _____ Relationship _____

Address_____

Primary Phone (____) _____ Secondary Phone (____) _____

Power of Attorney? ❑ Yes (Provide copy) ❑No **Court Appointed Guardian?** ❑ Yes (Provide copy)❑ No

E-mail: _____

NOTIFY IN CASE OF EMERGENCY

First Preference _____ Relationship _____

Primary Phone (____) _____ Secondary Phone (____) _____

Second Preference_____ Relationship_____

Primary Phone (____) _____ Secondary Phone (____) _____

PROSPECTIVE RESIDENT COMING FROM (Please Check)

❑Home ❑Hospital ❑Other Facility

Name of Hospital or Facility: _____

INSURANCE INFORMATION

Applicant's Insurance Information:

1. Medicare _____
   NAME **MEDICARE NUMBER**

2. Insurance _____
   NAME OF INSURANCE **NAME INSURANCE UNDER** **INSURANCE CARD NO.**

3. Insurance _____
   NAME OF INSURANCE **NAME INSURANCE UNDER** **INSURANCE CARD NO.**

4. Medicaid _____
   NAME **MEDICAID NUMBER**

5. LTC Insurance _____
   NAME OF INSURANCE **NAME INSURANCE UNDER** **INSURANCE CARD NO.**

FINANCIAL RESOURCES

Applicant's Source of Income:	**Dollar Amount**		
Retirement/Pension	_____	❑monthly	❑ annually
Investment Income	_____	❑ monthly	❑ annually
Social Security (SSA)	_____	❑ monthly	❑ annually
Civil Service Annuity	_____	❑monthly	❑annually
Veterans	_____	❑monthly	❑ annually
Supplemental Security Income (SSI)	_____	❑monthly	❑annually
Other (specify)	_____	❑monthly	❑ annually
Other (specify)	_____	❑monthly	❑annually

Applicant's Assets:	**Type/Location**	**Total Value / Balance**
Real Estate, Specify Type/Location		
Real Estate, Specify Type/Location		
Personal Property, Specify Type		
Personal Property, Specify Type		
Bank Accounts:		
Checking		
Savings		
CD's		
IRA		
401K / 403B		
Other bank account		
Insurance Policies		
Insurance Annuities/ (Cash Value)		
Burial Fund? Yes No	Is it irrevocable? *Yes* No	

Applicant's Liabilities:	**Dollar Amount**		
Rent		❑ monthly	❑ annually
Credit Cards		❑ monthly	❑ annually
Insurance Premiums		❑ monthly	❑ annually
Mortgage, Primary		❑ monthly	❑annually
Mortgage, Secondary		❑ monthly	❑ annually
Alimony		❑ monthly	❑ annually
Other (specify)		❑monthly	❑annually
Other (specify)		❑monthly	❑annually

DECLARATION OF CONFIRMATION

I / We hereby confirm that all information stated in this document is current and correct to the best of my/our knowledge and no requested information has been withheld or misrepresented. I/We authorize **Inova Loudoun Nursing and Rehabilitation Center** to verify any of the above information. I / We understand that falsification of the stated information may jeopardize admission into the Healthcare Center. All information will be kept confidential by **Inova Loudoun Nursing and Rehabilitation Center** and will not be released without my written permission.

Signature: _____ Date: _____

REQUIRED ADMISSION SUPPLEMENTS

1. Chest X-Ray results or a negative **PPD** report obtained prior to admission. (Performed within the past thirty (30) days).
2. A current history and physical (performed within the past thirty (30) days) from the applicant's physician.
3. A copy of the applicant's Social Security card, as well as copies of all insurance cards (Medicare, Blue Cross/Blue Shield, Medicaid, etc.)
4. A verification of the Mental Illness/Mental Retardation Screening.
5. A copy of any legal guardianship or current power of attorney and advance directive (living will or durable health care power of attorney) if applicable.
6. Current Bank Statement
7. Additional Financial Statements if applicable

INOVA LOUDOUN NURSING AND REHABILITATION CENTER
ADMISSION POLICIES AND PROCESS

Inova Loudoun Nursing and Rehabilitation Center is licensed by the Department of Health, Office of Licensure and Certification, and certified to participate both in the Virginia Medical Assistance Program (Medicaid) and in the Medicare program. In addition, the Inova Loudoun Nursing and Rehabilitation Center is accredited by The Joint Commission.

Inova Loudoun Nursing and Rehabilitation Center admits adult residents without regard to race, sex, age, religion or handicap. Admissions will be confined to applicants to whom the Center can safely and adequately provide care and services. Because of our rural setting, priority for admission will be given to Loudoun County residents.

Inova Loudoun Nursing and Rehabilitation Center is a **non-smoking facility**.

The applicant must be admitted by a physician having clinical privileges at Inova Loudoun Nursing and Rehabilitation Center. You are required to contact the physician and have the physician's agreement to follow the applicant through the admission process and thereafter.

Please review the List of Charges (attached) for the cost for room, board and care, including our estimate of extra costs for pharmacy, supplies, etc. Estimate the cost for a six-month period. If it appears that the applicant's resources are not adequate to cover that first six months (180 days), you will need to check with your local Department of Social Services to determine the applicant's eligibility of Virginia Medicaid for nursing home care. If Medicaid will be needed as a payment source within 180 days of admission, a screening/authorization must be done prior to admission. The screening is done to assure the Virginia Medical Assistance Program that the applicant needs nursing home care. For the pre-screening, contact the applicant's local Department of Social Services to get instructions on the eligibility determination. If in the hospital, contact the hospital Case Manager.

After the applicant's records are reviewed and he/she is accepted for admission, the Resident Representative and/or applicant will be expected to set up an appointment with the Admissions representative to review and sign the Inova Loudoun Nursing and Rehabilitation Center admission agreement **prior** to the expected admission date. Please bring in the applicant's Medicare, Medicaid and insurance cards, Advance Directive (if any), and any document relating to Power of Attorney or legal guardianship. Copies of these will be made for the Center's records.

LIST OF CHARGES EFFECTIVE 1/1/2018

Daily Rates:

Long Term Care Semi-private room	**$365.00 per day**
Long Term Care Private room	**$395.00 per day**
Skilled Care Semi-private room	**$670.00 per day**
Skilled Care Private room	**$670.00 per day**

Your daily rate includes the following services, regardless of payment source:

- oversight by a licensed nursing facility administrator
- medical direction by a licensed physician
- twenty-four hour licensed nursing care
- full-time dietary services overseen by a registered dietitian
- ongoing activities program
- medical social services
- incontinence care and management
- in-room telephone service
- housekeeping services
- maintenance services
- linen service for facility linens
- television/cable

Ancillary charges not covered, which include personal laundry (except clients covered by Medicaid) and beauty shop and barber services, may be charged to your resident fund account or your Resident Representative when the service or item is requested by you or your representative. A minimum of sixty (60) days' notice will be given to you or your representative before any change in charges or services.

PRIVATE PAY, MEDICARE AND COMMERCIAL INSURANCE CLIENTS

Unless covered by your insurance company, you may be charged for the following services when they are prescribed, requested and used. We will either bill your carrier directly or assist you in billing your insurance company.

ANCILLARY SERVICES

- personal comfort items, notions and novelties
- cosmetic and grooming items
- beauty and barber shop services
- personal clothing, personal reading material
- social events and outside entertainment offered outside the scope of the activities program
- transportation
- customized or specialized equipment to carry out medical treatments or care
- drugs and biological (billed by Pharmacy)
- specialized physician services and diagnostic studies
- rehabilitative therapies
- personal laundry
- oxygen and related supplies
- guest meals
- bed hold during periods of absence, when desired

During a Skilled stay under Medicare Part A, Days 1-20 are covered in full. For Days 21-100, a co-insurance is assessed daily. The co-insurance rate is set annually by Medicare.

*** Please note that all Medicare Skilled coverage is subject to meeting Medicare criteria for Skilled services.**

CLIENTS COVERED BY MEDICAID

The following additional services are included as part of your Medicaid benefits and will not be charged to you or your representative:

> Routine personal hygiene items including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents required to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over-the-counter drugs, hair and nail hygiene services, bathing and basic personal laundry.

The following ancillary services or items may be charged to your resident fund or Resident Representative when you or your representative requests the services:

- personal comfort items, notions and novelties
- cosmetic and grooming items and services in excess of those identified above
- personal clothing
- personal reading material
- social events and entertainment offered outside the scope of the activities program
- non-covered special care services such as privately hired nurses or aides
- specialized, individualized equipment not covered by Medicaid for nursing facility residents (i.e., certain eyeglasses, customized wheelchairs, routine dental care, etc.)
- beauty and barber shop services
- guest meals
- bed holding during periods of absence, when desired
- transportation to a non-Medicaid covered service

YOU WILL BE INFORMED OF THE COST OF EACH SERVICE THAT YOU OR YOUR REPRESENTATIVE REQUESTS TO BE PROVIDED. INOVA LOUDOUN NURSING AND REHABILITATION CENTER WILL MAINTAIN A DETAILED ACCOUNTING OF ALL CHARGES AND DEPOSITS MADE TO YOUR RESIDENT FUND ACCOUNT.

CHARGES WILL BE MADE ONLY FOR SERVICES OR ITEMS REQUESTED AND PROVIDED.

I have read the foregoing and understand that the Resident will be financially responsible for ancillary services and items provided outside the scope of the daily rate for nursing facility services.

By:
Inova Loudoun Nursing and Rehabilitation Center

Facility Representative Name and Title	Printed Resident Name
Facility Representative Signature	Resident Signature
Date _____	Date _____

Name of Authorized Representative and/or POA: _____

Authorized Representative and/or POA Signature _____

Date _____

Authority / Relationship to Resident: _____

Date of Appointment: _____

Authorized Representative Address: _____

Authorizes Representative Phone: _____

INOVA LOUDOUN NURSING AND REHABILITATION CENTER

INOVA LOUDOUN NURSING AND REHABILITATION CENTER
235 OLD WATERFORD ROAD, N.W.
LEESBURG, VA 20176

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

_____
Medical Record Number

Patient's Name _____ _____
(At time of treatment) Birth Date

Address _____ _____
(Include Street, City, State, Zip) Phone Number

1 .The undersigned hereby authorizes and requests Inova Loudoun Nursing and Rehabilitation Center to obtain

( ) Any necessary documents

_____

_____

(Identity of third party or name of any duly authorized representative. Include address [Street, City, State, and Zip]).

to my medical records for the purposes of review and examination and further authorizes and requests that you provide such copies thereof as may be requested.

(OR)
2. The foregoing is subject to such limitations as indicated below:
( ) Covering records for the period from _____ to _____.
(Date) (Date)

( ) Confined to the following specified information:

_____	Discharge Summary	_____	History & Physical
_____	Lab and X-Ray Findings	_____	Operative Report and Pathology Report
_____	Progress Notes	_____	Emergency Room Record
_____	Outpatient Record	_____	Physician's Orders
_____	Nurses Notes	_____	Other (Please specify): _____

3. ( ) No limitations placed on dates, history of illness, diagnostic and therapeutic information, including any treatment for alcohol and drug abuse. (Signer to initial for authentication of this response.) _____

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand that written notification is necessary to cancel the authorization and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand Inova Health System may not condition treatment on my decision to sign this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure or information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. (Information disclosed

regarding treatment for alcohol and/or drug abuse is protected by Federal law. Federal regulations (Title 42 CFR Part 2) prohibit anyone from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations).

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part2).

This consent will be revoked upon compliance of this request and will not serve for any other future request.

_____ _____

Date Signature of Patient

_____ _____

Date Signature of Legal Representative

_____

Relationship to Patient

_____

Facility Representative

INOVA®
Loudoun Nursing and Rehabilitation Center

PHYSICIANS WHO HAVE ADMITTING/ATTENDING PRIVILEGES AT INOVA LOUDOUN NURSING AND REHABILITATION CENTER (as of January 2019)

Please be sure to check with your current physician to see whether he/she has privileges at ILNRC. If he/she does not, you will need to contact a physician who does have privileges.

NAME	***ADDRESS***
Knudson, William E., Jr, DPM	224 D Cornwall Street, Suite 203 Leesburg, VA 20176 703-777-5830; Fax 703-777-5155
Palagiri, Vandana, MD Internal Medicine	Virginia Premium Medical Care 44790 Maynard Square, Suite 320 Ashburn, VA 20147 571-206-8696; Fax 866-383-4386
Paluvoi, Sobha R., MD Psychiatrist	19415 Deerfield Avenue, Suite 210 Lansdowne, VA 20176 703-738-9982; Fax 703-729-8477
Rustogi, Alok, MD Internal Medicine	Internal Medicine Practice Associates 46090 Lake Center Plaza, Suite 201 Potomac Falls, VA 20165 703-444-6544; Fax 866-374-3389
Swiger, Ralph, DDS Dentist	211 Gibson St., N.W., Suite 110 Leesburg, VA 20176 703-777-6100; Fax 703-777-6032
Ujevic, Neven A., MD Internal Medicine	235 Old Waterford Road, N.W. Leesburg, VA 20176 Office: 703 293 5242 Fax 571-313-8053
Manchireddy, Suman, MD Internal Medicine	Reliant MD Group, LLC 19415 Deerfield Avenue, Suite 103 Leesburg, VA 20176 Office: 571-351-4833 Fax 571-351-4854

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Revised: 5/12.....11/18; 12/18; 1/19