Marycrest Manor
Skilled Nursing Facility

September 1, 2021

Dear Friends,

Marycrest Manor is a skilled nursing facility sponsored by the Carmelite Sisters of the Most Sacred Heart of Los Angeles. As a licensed SNF, Marycrest provides 24-hour nursing care; recreational, educational, social and religious activities (such as daily exercise program, bingo, coffee socials, outdoor BBQ's, prayer services and Communion Services) for those who wish to attend; three delicious and nutritious meals with between meal snacks. Services are provided in a warm, home-like environment where our residents are cared for with love, dignity and respect.

The mission of the Carmelite Sisters in health care is to be ***"at the service of the family for LIFE (Living in Faith Everyday)"*** through the provision of health and residential care services.

Marycrest Manor has accommodations for 57 beds within two separate buildings – Marycrest and St. Joseph wings. Quality of care, nursing staff, activities and all services provided are the same between the two wings. Rate differences are reflective of room sizes. Rooms in the Marycrest wing are larger than those in the St. Joseph wing. Each room is provided with restroom, spacious closet and outdoor patio area. Rates below include the basic room charge, 24-hour nursing care, meals, activities, pastoral care, room cleaning, and social services. Medicare does not pay for long-term care in a nursing home. There may be some ancillary charges that are not covered in the basic room rate. After the initial application has been reviewed by our Admissions Coordinator and Director of Nurses, and the candidate is seriously being considered for admission, there may be an on-site pre-admission clinical nursing assessment.

Marycrest Wing

Single, private room	$401.00 per day
Double, semi-private room	$317.00 per day

St. Joseph Wing

Single, private room	$355.00 per day
Double, semi-private room	$299.00 per day
Four-bed Unit	$297.00 per day

If you have any questions or want to schedule a tour of our facility, please call 310 838-2778 ext. 212. We are happy to be of service to you and your loved one. Until then, we pray that God shower His abundant blessings upon you and your loved ones!

Sincerely in Christ,

S. Veronica, OCD

Sister Veronica, OCD
Administrator

Marycrest Manor
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Application for Admission

PATIENT INFORMATION

Date: _____

Name: _____ Date of Birth: _____ Age: _____ Sex: ____

Address: _____
Street City State Zip Code

Home Phone: _____ Religion: _____ Marital Status: S ☐ M ☐ W ☐ D ☐

Birthplace: _____ Social Security Number: _____
City/State

Medicare Number: _____ Medi-Cal Number: _____

Health Insurance: _____
Company Cert. # Gr/Policy #

HMO: _____ Affiliated Group: _____

Physician: _____ Phone: _____

HOSPITALIZATION

Have you been hospitalized in the last 12 months? Yes ☐ No ☐ If yes, please, complete the following.

Hospital: _____ Admit Date: _____ Discharge Date: _____

Skilled Nursing Facility: _____ Admit Date: _____ Discharge Date: _____

Patient is now at: _____ Admit Date: _____

IN CASE OF EMERGENCY NOTIFY:

Mr. ☐ Mrs. ☐ Miss ☐ Ms ☐

Name: _____ Relationship: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Office Phone: _____ Mobile Phone: _____

Mr. ☐ Mrs. ☐ Miss ☐ Ms ☐

Name: _____ Relationship: _____

Address: _____
Street City State Zip Code

Home Phone: _____ Office Phone: _____ Mobile Phone: _____

RESPONSIBLE PARTY

Mr. ☐ Mrs. ☐ Miss ☐ Ms ☐

Name: _____ Relationship: _____

Home Phone: _____ Office Phone: _____ Mobile Phone: _____

Address: _____
Street City State Zip Code

Charge Account to: _____
Name Address Phone

MORTUARY: State of California requires that the name of a mortuary be designated.

Name: _____ Phone: _____

Address: _____
Street City State Zip Code

Have pre-need arrangements been made? Yes ☐ No ☐

Food Preferences Interview

Admission Date: _____ Interview Date: _____

Current Diet Order: _____

Food Allergies: _____ Informant: ❑ Resident ❑ Other: _____

Food Intolerance: _____

Ethnic/Religious preferences: _____

Beverages: (Please circle the beverages that you would prefer at each meal)

Breakfast:	Whole Milk	2% Milk	Skim Milk	Lactaid Milk	Orange Juice	Apple Juice
	Cranberry Juice	Other _____		Coffee	Decaffeinated Coffee	Tea
	Decaffeinated Tea	Water				
Lunch:	Whole Milk	2% Milk	Skim Milk	Lactaid Milk	Iced Tea	Punch
	_____ Juice	Other _____		Coffee	Decaffeinated Coffee	Tea
	Decaffeinated Tea	Water				
Dinner:	Whole Milk	2% Milk	Skim Milk	Lactaid Milk	Iced Tea	Punch
	_____ Juice	Other _____		Coffee	Decaffeinated Coffee	Tea
	Decaffeinated Tea	Water				

Between meal beverage preference:

Snacks:

1. Did you have between meal snacks at home?

2. Any requested snacks?

Herbal Rememdies or supplement use at home?

NAME - Last	First	Middle	Record No.:

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REQUEST FOR ACCESS TO MEDICAL RECORD

Re: Patient's Name: _____

Date of Birth: _____

Approximate Date of Treatment: _____

I hereby request that _____ provide access to the
(name of hospital or other provider)

medical record of the patient named below. I request this access as the: (check one)

_____ Patient

_____ Durable Power of Attorney – Health Care

_____ Conservator of the person

The type of access required is: (check one)

_____ Inspection of the record

_____ Copies of the record as follows:

I request access to: (check one)

_____ Entire record

_____ Following portions of the record only: (specify)

_____

_____

Name: _____
(please print)

Signature: _____ Date: _____

10664 St. James Drive * Culver City * California 90230 * (310) 838-2778 * (310) 838-9647 fax

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The following documents are required for Marycrest Manor to make a decision regarding Admission.

Please Provide The Following Medical Records:

- H & P (History and Physical)
- Covid-19 Testing (5 days prior ok)
- Consults
- Medical Sheets (Current Medications)
- X-Rays (ie. chest, etc.)
- EKGs
- Laboratory Work (Include blood transfusions) - Any culture reports
- Surgery Reports, if applicable
- Rehab progress notes - evaluation & progress notes
- Does patient have any wounds or skin problems/rashes?
- MRSA past or present? MRSA/VRE/ESBL Screen - Any Isolation?
- Any IVs?
- Dietary Information (type of diet/type of liquids/feeding tube formula & frequency)
- POLST/Advance Directive
- Current height/weight
- Flu & pneumonia vaccines & dates
- [Social Worker Notes (psycho-social well being, mood state & discharge planning]

Admissions Office - P - 310 838-2778 Ext. 212
Fax - 310 838-9647
email: boa@marycrestculvercity.com

Marycrest Manor
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Doctor Telephone List

Dr. Douglas Tyler	310 828-0733	310 828-0711 Fax
Dr. Yulionas Gayauskas	310 695-9911	310 695-9922 Fax

Please call one of the above doctors to request that they agree to see your loved one as a new patient here at Marycrest Manor. Please inform us as to which doctor has been selected.

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Marycrest Manor
10664 St. James Drive
Culver City California 90230-5461

POLICIES AND PROCEDURES	
Subject: Ethical Policies	Department: Facility-wide
Submitted by: Administration	Page 1 of 1
Administrative Approval: Administrator	Effective Date: September 2004

POLICY: It is the policy of Marycrest Manor to:

1. Respect the right, within the law, of all residents' personal and informational privacy.

2. Upon admission, inform each resident of the right, under the law, to execute an advance directive. Document the existence or non-existence of an advance directive in the resident's record.

3. Provide a safe and secure environment for all residents.

4. Inform each resident of the identity and professional status of individuals providing care and services.

5. Provide each resident or resident's agent with complete and current information about his/her condition (diagnosis, treatment and prognosis) in terms that are understandable.

6. Provide appropriate palliative care (pain control and comfort measures) for all residents.

7. Provide basic care to all residents regardless of age, disability or dependency. Basic care includes food and fluids (nutrition and hydration), hygiene and prevention of complications caused by immobility unless:
   - the actual provision of the care is excessively burdensome or painful, or
   - death is truly imminent so that the absence of the care does not hasten death and is not needed for comfort, or
   - in the case of food and fluids, the nutrition and hydration cannot be assimilated.

8. Transfer the resident to a hospital, if necessary, for initiation of comfort or basic care measures (e.g. setting a broken bone, instituting assisted feeding, commencing and modifying some type of pain management, etc.)

9. Respect the right of residents to make their own health care decisions. If a resident's decision is contrary to its Principles or Policies, Marycrest Manor will assist the resident in transferring to another facility. It is the responsibility of the resident, not that of Marycrest Manor, to locate another facility.

10. Respect the right of resident's legally designated health care agent, surrogate or conservator to make health care decisions if the resident is incapable of making such decisions. If a decision of a resident's agent, surrogate or conservator is contrary to its Principles or Policies, Marycrest Manor will assist in transferring the resident to another facility. It is the responsibility of the resident's agent, surrogate or conservator, not that of Marycrest Manor, to locate another facility.

11. Provide a mechanism for residents or their agents, surrogates or conservators to bring concerns or complaints regarding care and services without recrimination.

MARYCREST MANOR SKILLED NURSING FACILITY APPLICATION
Resident Financial Information Statement

Marycrest Manor respects the privacy of every applicant. This information will be kept strictly confidential.

I. Please complete all areas. If an item does not apply to you, please write "N/A" in the accompanying field.

Fixed Income

	Monthly ($)	Annual ($)
Employment		
Social Security		
Pension		
Annuities		
Other _____		
Total		

Family/Other Assistance

Name	Telephone Number	Relationship	Amount Willing to Contribute ($)

Assets

	Market Value ($)	Monthly Income ($)	Annual Income ($)
Securities (Stocks, Bonds)			
Real Property			
Checking Account(s)			
Savings Account(s)			
Other _____			
Total			

Liabilities

	Liability Amount ($)	Lienholder(s)	Current Status
Real Estate Mortgages			
Personal Loans and Debt			
Chattel Mortgages			
Other _____			

Legally Responsible Party for Finances: _____

Contact (if other than you): Telephone _____ Address _____

MARYCREST MANOR SKILLED NURSING FACILITY APPLICATION
Resident Financial Information

II. Please provide contact information for the following persons whose services you use. By providing the information, you acknowledge and agree that the information may be used by Marycrest Manor to confirm your financial information.

Banker

Full Name _____ Bank Name _____

Address _____ Phone Number _____

Stockbroker

Full Name _____ Firm Name _____

Address _____ Phone Number _____

Lawyer

Full Name _____ Firm Name _____

Address _____ Phone Number _____

Trustee

Full Name _____ Relationship to Applicant _____

Address _____ Phone Number _____

III. To ensure the efficient processing of your application, all entries on the Financial Information Statement must be accompanied by supporting documentation. Please provide copies of the following financial records:

- Most recent **tax return**
- Most recent **bank statements** for a three-month period
- Most current billing statement for all **charge accounts** and lines of credit
- **Securities account statement** for a three-month period (e.g. brokerage, annuities, IRA, 401K, etc.)

Marycrest Manor will not share or otherwise disclose your private financial information to third parties. All documents are used solely for the purpose of determining qualification for admission. Should you need assistance in understanding which documents are needed, please do not hesitate to contact our admissions staff.

MARYCREST MANOR SKILLED NURSING FACILITY APPLICATION
Credit Report Authorization and Release

I hereby authorize Marycrest Manor and its agents to obtain a consumer credit report of my credit record through a credit reporting agency chosen by Marycrest Manor.

I understand and agree that Marycrest Manor intends to use the information from that report for the purpose of evaluating my admissibility for residency. My signature below authorizes the release to the credit reporting agency of financial information which I have supplied to Marycrest Manor in connection with such an evaluation. Authorization is further granted to the credit reporting agency to use a copy of this form if required to obtain any information necessary to complete my consumer credit report.

Last Name	First Name	M.I.
Social Security Number	Date of Birth (MM/DD/YYYY)	
Street Address		
City	State	Zip Code
Phone Number (Home)	Phone Number (Mobile)	
Applicant Signature	**Date**	

Declaration & Signatures

I declare that the above information is true and correct to the best of my knowledge and belief, and that it is submitted as part of an application for residency. If at any time any of the information set forth in this application should change, I understand that I must promptly furnish any necessary or appropriate correcting information to Marycrest Manor.

I further represent and declare that should I be admitted to Marycrest Manor, the assets disclosed on this form will be used first to pay for my private pay care at this facility for the remainder of my stay, that only amounts that are in excess of those needed for my care will be used for my additional living expenses. I certify that no assets will be intentionally spent, divested, transferred, or disposed of so that I may become impoverished or my ability to pay the full rate for such care is impaired, and acknowledge that undertaking such prohibited actions will be considered a breach of my contractual obligation.

I declare that I have read and understand the application instructions, the declarations, and all information printed on this application. I understand that falsifying or withholding pertinent information on this application may be grounds for the termination of my application or residency at Marycrest Manor.

_____ _____

Applicant **Date**

_____ _____

Legally Responsible Party for Applicant's Finances **Date**