

Delinquent Facility Accounts Information and Referral Form

This form may be completed by county Adult Protective Services (APS) staff or staff of long term care or assisted living residences. The information will be used by APS to determine what, if any, APS response is appropriate.

1. IDENTIFYING INFORMATION

Facility Name: _____ Phone: _____

Address: _____

Facility Social Worker: _____

Facility Administrator: _____

Resident's Name: _____ DOB: _____

Party Responsible for Payment: _____ Phone: _____

Party's Relationship to Resident: _____

Reporter's Name: _____ Position: _____

2. RESIDENT STATUS

The resident is capable of making financial decisions. Yes No

The resident believes that care payment arrangements are secure. Yes No

The resident understands that his/her bill is not being paid and:

- Will soon have funds sent directly to the resident. Yes No
- Agrees to appoint the facility as representative payee. Yes No

The resident declines to pay the unpaid account. Yes No

The resident is unable to facilitate payment of the unpaid account. Yes No

An eviction notice has been sent to the resident and responsible party. Yes No

The resident and/or the Long Term Care Ombudsman are appealing the eviction. Yes No

The resident has been evicted from other facility due to non-payment. Yes No

3. ACTIONS TAKEN BY THE FACILITY

Has a discharge plan been developed for the resident? Yes No

If so, to where will the resident be discharged? _____

Date of pending discharge _____

How many months has the account been unpaid? _____

What is the unpaid account balance? \$_____

Has the non-payment issue been referred to any of the following: (Check all that apply.)

- Attorney
- Collection Agency
- Ombudsman

Has the responsible party responded to phone calls/messages? Yes No

Has the facility sent a registered letter(s) to the responsible party? Yes No

Has the responsible party responded to the registered letter(s)? Yes No

4. FINANCIAL AUTHORITY

Check types:

Check if document is at facility*:

- | | |
|--|--------------------------|
| <input type="checkbox"/> Court Appointed Guardian | <input type="checkbox"/> |
| <input type="checkbox"/> Court Appointed Conservator | <input type="checkbox"/> |
| <input type="checkbox"/> Medical Durable Power Of Attorney w/ Financial Authority | <input type="checkbox"/> |
| <input type="checkbox"/> Medical Durable Power Of Attorney w/o Financial Authority | <input type="checkbox"/> |
| <input type="checkbox"/> Financial Durable Power Of Attorney | <input type="checkbox"/> |
| <input type="checkbox"/> General Financial Power Of Attorney | <input type="checkbox"/> |
| <input type="checkbox"/> Representative Payee | <input type="checkbox"/> |
| <input type="checkbox"/> Trustee/Trust Administrator | <input type="checkbox"/> |
| <input type="checkbox"/> Written Agreement With Facility For Account Payment | <input type="checkbox"/> |
| <input type="checkbox"/> Verbal Agreement With Facility For Account Payment | <input type="checkbox"/> |

A. Name: _____ Phone: _____

Authority: _____ Relationship to resident: _____

B. Name: _____ Phone: _____

Authority: _____ Relationship to resident: _____

* It is recommended that the facility maintain a copy of documents in the resident's file.

5. SOCIAL SECURITY STATUS

Has the facility reported concerns regarding the delinquent account to the Social Security Administration? Yes No

Has anyone applied for representative payee designation? Yes No
If yes, who? _____ Date applied: _____

Has anyone received representative payee designation? Yes No
If yes, who? _____ Date designated: _____

6. MEDICAID STATUS/ AP 5615 FORM:

- Approved for Medicaid Has Not Applied for Medicaid
 Pending - Date of application: _____ AP-5615 FORM sent to County: _____
 Denied AP-5615 FORM returned to facility

7. RESIDENT'S MONTHLY INCOME, ASSETS, AND DEBTS (Enter value for each.)

<u>INCOME</u>	<u>ASSETS</u>	<u>EXPENSES</u>
SSA/SSDI \$ _____	Home(s) \$ _____	Facility Costs \$ _____
SSI \$ _____	Land \$ _____	Co-pay \$ _____
Medicaid \$ _____	Business \$ _____	Insurance \$ _____
RR \$ _____	Savings \$ _____	Loan \$ _____
VA \$ _____	Retirement \$ _____	Loan \$ _____
Black Lung \$ _____	Trusts \$ _____	Other \$ _____
Other \$ _____	Other \$ _____	Other \$ _____
Total \$ _____	Total \$ _____	Total \$ _____

8. INDICATORS OF POSSIBLE FINANCIAL EXPLOITATION (Check all that apply.)

While the resident lacked capacity:

- The resident signed checks or important documents, such as a will or Power Of Attorney (POA) instrument.
 A title change took place for the resident's home or other valuable assets.

The responsible party, fiduciary, or family member:

- Is suspected of spending the resident's money on purchases for his/her own use.
 Is suspected of not paying numerous other bills in addition to the facility bill.
 Is a recent acquaintance that expresses unusually deep affection for the resident.
 Has a POA signed and dated when the resident lacked capacity to understand such action.
 Is evasive about or tells implausible, confusing stories about finances to resident or others.
 Isolates or alienates the resident from contact with others.
 Refuses to spend money for appropriate care of the resident.
 Exhibits unusual concern that too much money is being spent on the resident's care.
 Promised the resident life long care in exchange for assets or changes in the resident's will.

Other:

- The resident lacks common personal items that he/she could afford.
 The resident with capacity signed papers, but doesn't know what was signed.
 Signatures on checks and documents do not resemble the resident's signature.
 The resident writes numerous checks or there is unusual bank activity, such as withdrawals from an ATM when the resident cannot get to an ATM.
 Other _____

Name of person completing this form: _____ Date: _____