



Application and Care Agreement
For those radically relying on Christian Science for healing

Applicant's Full Name _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

Phone _____ County _____ Date of Birth _____

Place of Birth _____ Medicare No. _____

Social Security No. _____ Father's Name _____

Mother's Maiden Name _____ Marital Status _____

Spouse' Name _____ Street Address _____

City _____ State _____ Zip _____ Phone _____

Next of Kin _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

Next of Kin _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

Are you a member of The Mother Church? _____ A branch church? _____

If not a member, how long have you been studying Christian Science? _____

Because individuals come to Clearview for healing, it is our policy that a Christian Science *Journal*-listed practitioner prayerfully support each Clearview guest every day.*

Journal listed practitioner _____ Phone _____

NURSING NEEDS

In order to properly plan for your care, we ask that you provide information as to what Christian Science nursing services you believe would be necessary and/or helpful to you.

Nature of difficulty: _____

Assistance needed with: Walking _____ Reading _____ Bathing _____ Eating _____

Bandaging _____ Getting dressed _____ During the night _____ Other _____

Have you had any medical or psychological treatment within the last three (3) years? _____

Please summarize the treatment:

FINANCIAL

Bills should be submitted to:

Name _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

How do you expect to pay the charges for nursing care _____

Clearview will bill you for nursing care on a monthly basis. Guests who anticipate that their insurance policies will cover care are **still required to pay Clearview**. You will then be reimbursed by your insurance company

Do you have financial power of attorney? _____

Name _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

Please provide a copy of your Power of Attorney documentation.

Is there a family member who would be financially responsible for care if your resources are exhausted?

Name _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

Guarantor's signature _____

MEDICARE

Medicare is a Federal program, which provides payment to participating individuals for health care at Clearview in situations where the care requires the skill of a Christian Science *Journal*-listed nurse.

If you qualify for Medicare, do you want the expenses of your stay submitted to Medicare?

Yes _____ No _____ If so, a Medicare Secondary Payer document must be completed. (Document #G23 of this packet.)

Guests qualifying for Medicare will be billed the Medicare deductible on their first bill from Clearview.

Have you received Medicare covered health care during the last sixty (60) days?

Yes _____ No _____

Name of facility _____

Address _____

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediaries or carriers, any information needed for this or a related medical claim. I request that payment or authorized benefits be made to Clearview Home Corporation on my behalf.

Initials _____ Date _____

ADVANCE DIRECTIVES FOR HEALTH CARE

Have you completed any Advance Directives for health care? Yes _____ No _____

Is there an appointed health care agent? _____

Name _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

Please provide a copy of your Advance Directives for Health Care. It is Clearview's policy to comply with all Advance Directives that do not conflict with the letter or the spirit of Christian Science nursing.

If no, the applicant acknowledges receipt of material informing the applicant of his/her right to formulate Advance Directives and his/her right to accept or refuse medical or surgical treatment.

Initials _____ Date _____

URGENT NEED

If you have a health care agent, that agent will be contacted in an urgent need situation.

If you do not have a health care agent, who should be contacted in an urgent need situation?

Name _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

Secondary Contact:

Name _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

RELIANCE ON CHRISTIAN SCIENCE FOR HEALING

Clearview's Mission Statement

To honor the wholeness of God's perfect man by offering the tender, uplifting care of Christian Science nursing.

Nursing care provided by Clearview Home includes:

- Caring for the individual through spiritual witnessing, nurturing, cherishing, and comforting.
- Personal care: Assistance with such things as bathing, commoding, oral care, and other services necessary to maintain one's cleanliness.
- Mobility assistance: Including help with the use of crutches, walker, or cane, or in actual positioning of the individual for comfort and normalcy while in a chair, in a bed, etc.
- Nourishment: Preparing and/or modification of food, assistance with feeding; also encouraging the individual being nursed to eat as appropriate.
- Bandaging: Proper cleaning and bandaging of wounds to provide for comfort, cleanliness, and cover.
- Instruction: Instructing the one being nursed, family members, or others who are helping with personal care, mobility, nourishment, and bandaging.
- Communication: Contacting the individual's practitioner or family members if she/he is unable to do so.
- Encouragement: Gently offering Christian encouragement in support of the individual's expression of life, vitality, and normal activity consistent with his/her needs.
- Reading aloud: Reading from the Bible, Science and Health with Key to the Scriptures, and other writings of Mary Baker Eddy and miscellaneous Christian Science literature.

Christian Science nursing does NOT include:

- Giving Christian Science treatment/ being responsible for healing.
- Being an intermediary between the individual being nursed and the Christian Science practitioner, or between the individual and his/her family.
- Giving advice and counsel.
- Diagnosing, recording, and maintaining a record of symptoms or conditions during the stay at the facility.
- Administering medication, drugs, medicated products or supplies.

- Use of cleansing solutions or other products, which are purported to aid healing or bring relief from pain, soreness, itching, etc.
- Using and administering medically-oriented techniques or equipment, which the nurse has not been trained to use.
- Manipulation, massages, therapeutic exercise (physical therapy).
- Force-feeding or intravenous feeding.

I fully understand and agree with the above statement and am seeking admission to Clearview Home for the purpose of communing with my Father-Mother God while radically relying on Christian Science treatment for healing. I also understand and support the Mission Statement of Clearview Home.

Guest's initials _____ Date _____

CONDITIONS OF ADMISSION

- I understand that each admission to Clearview is for the purpose of healing. Guest may be moved within the facility or asked to find alternate care provisions if the administration believes it is in the best interest of the guest and Clearview.
- I understand that admission to Clearview is made only after the approval of the Admission Committee.
- Clearview will make every effort to properly care for my belongings at Clearview but cannot guarantee their safekeeping.
- I have received a copy of "A Bill of Rights for Patients." (State required.)

Initials _____ Date _____

I request admittance to Clearview. I understand and agree to all the sections of this document.

Signature of the _____ Date _____

Signature of person filling out application if applicant is unable to _____

I hereby request and consent to the admission of the applicant to Clearview.

Signature of sponsor or guarantor _____

Relationship to applicant _____

RELEASE, WAIVER AND INDEMNITY AGREEMENT

It is my desire to rely exclusively on Christian Science care and treatment for any physical or health problem I may have or may develop while receiving care in a facility operated by Clearview Home Corporation, Inc. I do **not** wish to have or expect to receive any medical examination and diagnosis, or care and treatment of a medical nature while at this facility. I understand and acknowledge that the sole purpose of my admission is to receive Christian Science Nursing Care or Christian Science Care while also receiving Christian Science treatment from a *Journal*-listed practitioner of my choice; that the facility is not a medical hospital or any other type of medical facility and that it is not serviced by, nor will there be available any medical doctors or nurses.

In consideration of my admission upon these terms, I hereby release and discharge said facility and Clearview Home Corporation, Inc., its agents and employees, of any and all responsibility and liability in connection with, relating to, or arising out of their failure to furnish medical care or treatment, or to furnish or make available medical or surgical examinations and diagnoses, or to inform me of any information or condition which might be disclosed by such an examination or diagnosis; and I agree to indemnify and hold forever harmless said facility and Clearview Home Corporation Inc., its agents and employees and successors or assigns, heirs, executors and executive director against loss from any and all further claims, demands, or actions that may hereafter at any time be made or brought by me or anyone on behalf of me arising out of such aforesaid failure, for damages, injuries, costs and expenses of any kind to which I or they may be entitled under the laws of this or any other state.

I accept and understand the information in this application and the above Release, Waiver and Indemnity agreement.

Signature of Applicant for
Admission or Responsible Party _____

Date _____