SEARHC
SOUTHEAST ALASKA REGIONAL HEALTH CONSORTIUM

SEARHC Long-Term Care
Wrangell 907.874.7000| Sitka 907.747.3241

PRE-ADMISSION APPLICATION – Patient Form

GENERAL INFORMATION

Name _____ Age _____ Birthdate ____/____/____

Address _____ Social Security # _____

Spouse's Name _____ Age _____ Birthdate ____/____/____

Address _____ Social Security # _____

Physician'sName _____ Phone _____

Address _____

Long Term Care Physician of Choice _____

PATIENT INFORMATION

Applicant: □ Lives alone □ Lives with Family Member □ Other:_____

Living Will: □ Yes □ No □ Guardianship

Power of Attorney: □ Yes □ No If yes, Name: _____ Phone _____

Or Conservatorship: □ Yes □ No If yes, Name: _____ Phone _____

Do you have a Miller Trust? _____ Do you need assistance with a Miller Trust? _____

**Please Attach Documents*

If living somewhere other than a skilled nursing home, is applicant receiving any of the following services?

□ Health Aide □ Nursing services □ Physical Therapy

□ Personal Care Attendant □ Social Services □ Other: _____

Is applicant currently an inpatient at a hospital or been an inpatient within the last 30 days?

□ No □ Yes Admit Date ____/____/____ Discharge Date ____/____/____

Name and address of facility _____

Is applicant currently in a Rehab or Nursing Home or been in a Rehab or Nursing Home within the last 60 days?

□ No □ Yes Admit Date ____/____/____ Discharge Date ____/____/____

Name and address of facility _____

Is applicant presently employed? □ No □ Yes If yes, Employer: _____

Is spouse presently employed? □ No □ Yes If yes, Employer: _____

FINANCIAL INFORMATION

Each applicant must attach a copy of the most recent bank statement(s) and/or securities statement, and the local tax assessment on real or personal property for verification of assets. Should the financial situation change while living in the Long Term Care unit you will be expected to notify Patient Financial Services.

Name of Bank(s), Branch:

_____ □ Checking □ Saving

_____ □ Checking □ Saving

MEDICARE/MEDICAID INFORMATION

Medicare: □ Yes □ No

Part A □ Yes □ No

Part B □ Yes □ No

Part D □ Yes □ No

Medicare # _____ **Please Provide copy of Medicare Card*

Medicaid: □ Yes □ No □ Aid to Elderly □ Aid to Disabled

Medicaid # _____ Eligibility Date _____/____/_____ **Please Provide copy of Medicaid Card*

Other Insurance:

Name _____ Address _____ ID # _____

FINANCIAL RESOURCES

Applicant Income:

□ Public Assistance $_____ per month

□ Supplementary Security Income $_____ per month

□ Longevity Income $_____ per month

□ BIA $_____ per month

□ Social Security $_____ per Month

□ Veterans Benefits $_____ per Month

□ Requirement Annuity $_____ per month

□ Other Income $_____ per month

Spouce Income:

□ Public Assistance $_____ per month

□ Supplementary Security Income $_____ per month

□ Longevity Income $_____ per month

□ BIA $_____ per month

□ Social Security $_____ per Month

□ Veterans Benefits $_____ per Month

□ Requirement Annuity $_____ per month

□ Other Income $_____ per month

Other Resources	Other Resources	Value	Legal Owner
Real property (land & buildings)			
Car, boat, airplane, etc.			
Cash value of life insurance			
Stocks and bonds			
Other assets			

What assets have you disposed of, or changed the nature of in the past 5 years? _____

_____

ANY OTHER INFORMATION PERTINENT TO APPLICATION:

_____

_____

_____

CERTIFICATION SIGNATURES

I certify that to the best of my knowledge the information in this application is true and correct:

Applicant's Signature _____ Date _____/____/_____

If other than applicant signing, relationship

Printed Name _____ Phone _____

Address _____ Contact _____

Form completed by _____ Date _____/____/_____ Time_____