

## PRE-ADMISSION APPLICATION – Patient Form

### GENERAL INFORMATION

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Social Security # \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ Social Security # \_\_\_\_\_

Physician's Name \_\_\_\_\_ 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?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Health Aide             | <input type="checkbox"/> Nursing services | <input type="checkbox"/> Physical Therapy |
| <input type="checkbox"/> Personal Care Attendant | <input type="checkbox"/> Social Services  | <input type="checkbox"/> 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 \_\_\_\_\_

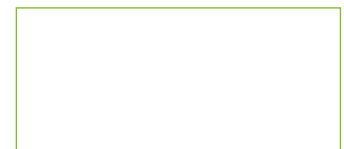
Is applicant currently in a Rehab or Nursing Home or been in a Rehab or Nursing Home within the last 60 days?

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

Spouse 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 \_\_\_\_\_

