

# BETHANY LIFE COMMUNITIES

## Admission Application

Date: \_\_\_\_\_

Applying for admission at:  Bethany Manor  Cedar Place Assisted or Independent  Timberland Assisted or Independent

Personal Inquiry					
Name of Applicant (Full first, middle, and last name)					Date of Birth
Street Address					City
State		Zip Code		Phone Number	
Marital Status			Current County of Residence		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced					
If Married or Widowed, Spouse's Name			Spouse's Past Occupation		
Spouse's Date of Birth		Spouse's Date of Retirement		If Applicable, Spouse's Date of Death	
Applicant's Past Occupation			Applicant's Date of Retirement		
Social Security Number		Place of Birth		Language	
United States Citizen		Race			
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian/Pacific Islander <input type="checkbox"/> Black, not Hispanic <input type="checkbox"/> Hispanic <input type="checkbox"/> White			
Are you or your spouse a veteran?		Approximate Dates of Service		Enlistment Number	Branch of Military
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Religion		If Applicable, Church Membership			
Financial Inquiry					
Will your residency be paid for privately?		If yes, name of person responsible for billing:		Responsible Party Phone Number	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Responsible Party Address		City	State	Zip Code	
Do you currently receive Medicaid benefits?		If yes, list Medicaid number:			
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Are you enrolled to receive Medicare Part A benefits?		If yes, list Medicare number:		Do you have Medicare Part B?	
<input type="checkbox"/> Yes <input type="checkbox"/> No				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have nursing home insurance?		If yes, please give name of insurer:		If applicable, list policy number:	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please give address of insurer:		City	State	Zip Code	
Do you have other health insurance?		If yes, please give name of insurer:		If applicable, list policy number:	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, please give address of insurer:		City	State	Zip Code	
Current monthly income:		Social Security	Pension	Other:	
		\$ /month	\$ /month	\$ /month	

Do your assets exceed \$75,000? <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you disposed of any assets in the last 3 years? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, please list:	
<i>Capital Assets:</i> (Please also list holdings jointly held)		Cash on hand \$	Cash held for you by others \$	By whom held?	
Name of Banks and/or Credit Union		Address of Financial Institution		Account Number/s	Amount
1.					\$
2.					\$
3.					\$
Stocks and/or Bonds			Number of Shares		Approximate Value
1.					\$
2.					\$
3.					\$
Real Estate (Owned and Mortgaged)		Address of Real Estate			Approximate Value
1.					\$
2.					\$
3.					\$
Insurance Policies		Policy Number	Amount	Beneficiary	
1.			\$		
2.			\$		
3.			\$		
<i>Debts and Obligations:</i>		Type			Amount
		1.			\$
		2.			\$
		3.			\$
<b>Health Inquiry</b>					
Please list current known medical diagnoses:					
Please check those Activities of Daily Living that you require assistance with:					
<input type="checkbox"/> Bathing <input type="checkbox"/> Toileting <input type="checkbox"/> Grooming <input type="checkbox"/> Eating <input type="checkbox"/> Bed Mobility <input type="checkbox"/> Ambulation <input type="checkbox"/> Dressing					
Please list the providers that you will utilize during your residence at Bethany Life Communities:					
Primary Care Physician	Phone Number	Alternate Physician (or specialist)		Phone Number	
	#			#	
Eye Doctor	Phone Number	Podiatrist		Phone Number	
	#			#	
Dentist	Phone Number	Psychiatrist		Phone Number	
	#			#	
Mortuary	Phone Number	Hospital		Phone Number	
	#			#	
Attorney	Phone Number	Pharmacy		Phone Number	
	#			#	

Please list any and all known allergies: (environmental, food, and medication)

Persons to be notified in case of emergency: (in order to be contacted)

Name	Phone Number	Relationship
1.		
2.		
3.		
4.		
5.		

Have you executed any of the following? (please include copies of all applicable documents with submission of application)

Living Will    Durable Power of Attorney for Healthcare Decisions    Financial Power of Attorney    Other:

Please provide any other information that may be helpful or important to include in order to process this application:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

According to my best knowledge and belief, the information disclosed in this admission application is complete, accurate, and true in all respects. I agree, if admitted, to abide by the admission agreement of Bethany Life Communities.

Signature of Applicant, or Person Completing This Application \_\_\_\_\_ Date \_\_\_\_\_

**\*\*Notice to applicant**–This application must be accompanied by any and all insurance cards (including Medicare) and social security card.

**Note:** This application does not constitute an admission agreement. Information submitted will be reviewed by Bethany Life Communities staff to determine if further admission procedures are advisable. No obligation is placed on either the applicant or Bethany Life Communities via submission of this application. The offer is accepted when the applicant named above enters Bethany Life Communities as a resident or a tenant, and it becomes part of the overall agreement between the applicant above and Bethany Life Communities. If the applicant makes no other arrangements, and/or no longer desires residency within Bethany Life Communities, this offer should be withdrawn by notice to Bethany Life Communities. When such notice is received, this Admission Application will be removed from the file.

Bethany Life Communities shall not deny admission to any resident solely based on the person’s financial inability to pay the full cost of their care. Bethany Life Communities is a charitable institution and in keeping with that charitable tradition provides services and care to its residents and/or tenants for less than the actual cost of providing care. Bethany Life Communities does have a Good Samaritan Fund available to assist residents and/or tenants who are or become unable to pay the full cost of their care. Applicants, residents, and/or tenants seeking such financial assistance are asked to contact the Bethany Life Foundation for more information concerning the availability of Good Samaritan Funds.

**For Office Use Only**  
If recent hospitalization, exact dates of stay:  
Date of Admission:  
Campus:    Bethany Manor    Cedar Place Assisted    Cedar Place Independent    Timberland Assisted    Timberland Independent  
Room Number:  
Pay Status Upon Admission:    Private    Medicaid    Medicare Part A    Other \_\_\_\_\_

Notes: