

BETHANY LIFE COMMUNITIES

Admission Application

Date: _____

Applying for admission: Short Term Rehab Long Term Care

Personal Inquiry				
Name of Applicant (Full first, middle, and last name)				Date of Birth
Street Address		City	State	Zip Code
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
<input type="checkbox"/> Yes <input type="checkbox"/> No				
Religion		If Applicable, Church Membership		
Financial Inquiry – Part A				
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

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Financial Inquiry – Part A (continued)			
What is your total annual income?			
<input type="checkbox"/> \$0 - \$25,000 <input type="checkbox"/> \$26,000 - \$50,000 <input type="checkbox"/> \$51,000 – \$75,000 <input type="checkbox"/> \$76,000 - \$100,000 <input type="checkbox"/> \$101,000 - \$125,000 <input type="checkbox"/> Over \$125,000/year			
What are your total liquid assets?			
<input type="checkbox"/> \$0 - \$50,000 <input type="checkbox"/> \$51,000 - \$100,000 <input type="checkbox"/> \$101,000 – \$150,000 <input type="checkbox"/> \$151,000 - \$200,000 <input type="checkbox"/> \$201,000 - \$250,000 <input type="checkbox"/> Over \$250,00			
Do you own any real estate?		If yes, list location:	
<input type="checkbox"/> Yes <input type="checkbox"/> No			
		If yes, approximate value:	
Health Inquiry			
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)			
<input type="checkbox"/> Living Will <input type="checkbox"/> Durable Power of Attorney for Healthcare Decisions <input type="checkbox"/> Financial Power of Attorney <input type="checkbox"/> Other:			

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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/all insurance cards as well as Medicare) and Social Security****

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. Benevolent support may be available for some residents who are not able to pay the full cost of their care. Application for such support may be made through the business office

For Office Use Only

If recent hospitalization, exact dates of stay: _____

Date of Admission: _____ Short Term Rehab Long Term Care

Date of Admission: _____ Short Term Rehab Long Term Care

Room Number Short Term Rehab: _____ Room Number – Long Term Care _____

Pay Status Upon Admission- Short Term Rehab: Private Medicaid Medicare Part A

Other _____

Pay Status Upon Admission- Long Term Care: Private Medicaid Medicare Part A

Other _____

Notes:

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Please return completed form to the front office by: _____

Financial Inquiry – Part B – Page 1 of 2				
Name of Applicant (Full first, middle, and last name)				Date of Birth
Street Address		City	State	Zip Code
				Phone Number
Current income	Self		Joint (spouse)	
Social Security				
Pension				
Annuity				
Interest/Investment Inc.				
Other - Specify				
	\$ /month	\$ /month		
Have you disposed of any assets in the last 5 years? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, please list below:
Type of asset	Dollar Value	Date Disposed	Recipient	
Capital Assets:	Cash on hand	Cash held for you by others	Held by whom?	
(Please also list holdings jointly held)	\$	\$		
Name of Banks and/or Credit Union	Address of Financial Institution	Account Number	Amount	
1.			\$	
2.			\$	
3.				
4.			\$	
Stocks and/or Bonds			Approximate Value	
1.			\$	
2.			\$	
3.				
4.			\$	
Real Estate Owned	Address of Real Estate			Approximate Value
1.				\$
2.				\$
3.				\$

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Financial Inquiry – Part B – Page 2 of 2

Insurance Policies - Company	Policy Number	Face Amount	Cash Value	Beneficiary
1.		\$	\$	
2.		\$	\$	
3.		\$	\$	
Burial Fund /Prepaid Burial Expenses	Phone No.	Date Established		Approximate Value/Cost
Debts and Obligations:				
Mortgage / Real Estate Loans				
Owed To		Monthly Payment		Amount Owning
				\$
				\$
				\$
Notes Payable				
Owed To		Monthly Payment		Amount Owning
				\$
				\$
				\$
Credit Card Debt				
Owed To				Amount Owning
				\$
				\$
				\$

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