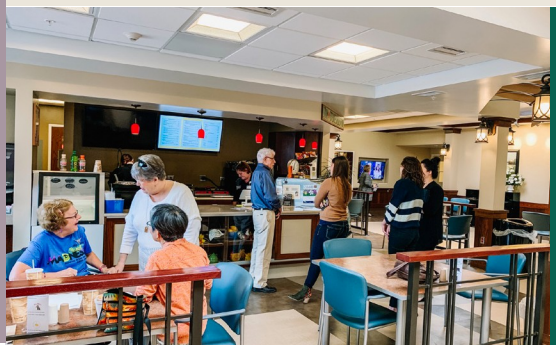
Bethany Life

APPLICATION FOR
ADMISSION

WELCOME

Our Mission

Bethany Life's mission is to help elders thrive in their life journey, living in a Christian environment of hope and compassion.



Admissions Application

The Households of Bethany

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**	**County**	**Phone Number**
Email Address				**How did you hear about us?**	
Race	**Ethnicity**	**Social Security Number**		**United States Citizen**	**Sex**
□ American Indian or Alaskan Native □ Asian □ Black or African American □ White □ Other	□ Hispanic or Latino □ Not Hispanic or Latino			□ Yes □ No	□ Male □ Female □ Do Not Wish to Disclose
Language	**Marital Status**			**If Married or Widowed, Spouse's Name**	
	□ Single □ Married □ Widowed □ Divorced				
Are You a Veteran?	**Is Your Spouse a Veteran?**	**Branch of Military**			
□ Yes □ No	□ Yes □ No				
Religion	**If Applicable, Church Membership**				

Financial Inquiry – Part A

Billing Address (Address of applicant or applicant's financial representative. Please do not list insurer)				Phone Number
Street Address	**City**	**State**	**Zip Code**	**County**
Do you currently receive Medicaid benefits?	**If yes, please list Medicaid number**			
□ Yes □ No				
Do you have Medicare Part A?	**Do you have Medicare Part B?**		**Policy Number**	
□ Yes □ No	□ Yes □ No			
Do you have a Medicare supplement?	**If yes, please list insurer**		**Policy Number**	
□ Yes □ No				
Do you have a Medicare Advantage plan?	**If yes, please list insurer**		**Policy Number**	
□ Yes □ No				
Do you have other Health Insurance?	**If yes, please list Insurer**		**Policy Number**	
□ Yes □ No				
Do you have long term care insurance?	**If yes, please list insurer**		**Policy Number**	
□ Yes □ No				
Address	**City, State & ZIP**		**Phone Number**	

Health Inquiry

Please list the providers that you will utilize during your residence at Bethany Life

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 (if established)	Phone Number	Hospital	Phone Number
	#		#
Attorney	Phone Number	Food Allergy	Medication Allergy
	#		

Other Allergies (please list any/all)

Persons to be notified in case of emergency (in order to be contacted with medical updates)

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 □ Power of Attorney for Healthcare Decisions □ Financial Power of Attorney □ IPOST □ Other:

Who is your Medical Power of Attorney? (Check if non-applicable)
□ N/A

If no Medical Power of Attorney, who should be contacted for medical questions/decisions?

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.

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 cards****

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

Bethany Life 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.

Bethany Life

212 Lafayette Ave.
Story City, IA 50248

(515) 733-4325
www.bethanylife.org

EQUAL HOUSING OPPORTUNITY

Revised January 2020