



Bethany Life

APPLICATION FOR ADMISSION



Our Mission

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

WELCOME



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	
<input type="checkbox"/> American Indian or Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black or African American <input type="checkbox"/> White <input type="checkbox"/> Other	<input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino		<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Do Not Wish to Disclose	
Language	Marital Status		If Married or Widowed, Spouse's Name		
<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced					
Are You a Veteran?	Is Your Spouse a Veteran?	Branch of Military			
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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			
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you have Medicare Part A?		Do you have Medicare Part B?		Policy Number	
<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Do you have a Medicare supplement?		If yes, please list insurer		Policy Number	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you have a Medicare Advantage plan?		If yes, please list insurer		Policy Number	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you have other Health Insurance?		If yes, please list Insurer		Policy Number	
<input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you have long term care insurance?		If yes, please list insurer		Policy Number	
<input type="checkbox"/> Yes <input type="checkbox"/> 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	Eye Doctor	Dentist	Mortuary (if established)
Attorney			
Persons to be notified in case of emergency (in order to be contacted with medical updates)			
Name	Cell Phone #	Home Phone #	Relationship
Email Address			
Name	Cell Phone #	Home Phone #	Relationship
Email Address			
Name	Cell Phone #	Home Phone #	Relationship
Email Address			
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"/> Power of Attorney for Healthcare Decisions <input type="checkbox"/> Financial Power of Attorney <input type="checkbox"/> IPOST <input type="checkbox"/> Other:			
Who is your Medical Power of Attorney? (Check if non-applicable)			
			<input type="checkbox"/> 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

