

# Application for Admission

**Name of Applicant** \_\_\_\_\_ ( ) Male ( ) Female  
Address \_\_\_\_\_ Telephone # \_\_\_\_\_  
City \_\_\_\_\_ County \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Spouse's Name \_\_\_\_\_  
SSN \_\_\_\_\_ Primary physician in community \_\_\_\_\_

**Reason for Application for Admission:**

- ( ) Short-term inpatient rehabilitation with subsequent discharge to home  
( ) Long-term custodial care

**Location of Applicant:**

- ( ) Home  
( ) Other residential facility: \_\_\_\_\_ Date of admission: \_\_\_\_\_  
( ) Hospital: \_\_\_\_\_ Attending physician / surgeon \_\_\_\_\_  
Date of admission \_\_\_\_\_ OR Date of scheduled surgery \_\_\_\_\_

Has physician / surgeon recommended Skilled Nursing Facility care? ( ) Yes ( ) No

**Responsible Parties**

Will Applicant act as his/her own Responsible Party / Financial Rep.? ( ) Yes ( ) No

**Responsible Party and/or Emergency Contact** (Oversees personal needs of applicant):

(If necessary, list additional contacts on separate page)

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

**Additional Emergency Contact:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

**Financial Representative** (If different from Applicant):

(Manages financial obligations of applicant, where applicant's bills are to be mailed):

Name \_\_\_\_\_ Relationship \_\_\_\_\_  
Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_

Durable Power of Attorney? ( ) Yes ( ) No Conservator/Guardian? ( ) Yes ( ) No

**How will applicant's care at Briody Health Care Facility be paid?**

( ) Medicare and/or Medical Insurance ( ) Medicaid ( ) Private Resources

**Insurance Coverage**

Medicare Number \_\_\_\_\_

Medical Insurance Carrier \_\_\_\_\_

ID # \_\_\_\_\_ Group ID # \_\_\_\_\_

**Prescription Drug Coverage**

Medicare Prescription Drug Plan: \_\_\_\_\_ ID# \_\_\_\_\_

Or, Other Prescription Drug Plan: \_\_\_\_\_ ID# \_\_\_\_\_

**Declaration of Finances**

Does the Applicant have Long-Term Care Insurance? ( ) Yes ( ) No  
 Name of Company: \_\_\_\_\_  
 Does Applicant receive Supplemental Security Income (SSI) benefits? ( ) Yes ( ) No  
 Has the Applicant applied for Medicaid? ( ) Yes ( ) No  
 Date of Initial Medicaid Appointment? \_\_\_\_\_  
 Name of Medicaid Social Worker?: \_\_\_\_\_  
 Has the Applicant been approved for Medicaid? ( ) Yes ( ) No  
 If Yes, Medicaid # \_\_\_\_\_ County \_\_\_\_\_

**Statement of Applicant's Resources:**

**Monthly Income**

	Applicant	Spouse
Social Security	_____	_____
Retirement / Pension	_____	_____
Regular Salary	_____	_____
Dividends / Interest income	_____	_____
Supplemental Security Income (SSI)	_____	_____
All other income	_____	_____
Total Monthly Income:	_____	_____

**Assets**

	Approximate Value
Primary residence	_____
Other real estate	_____
Checking / Money Market Accounts	_____
Savings / Term Accounts	_____
Other Assets (stocks, bonds, mutual funds, etc.)	_____
Prepaid funeral	_____
Total Assets:	_____

**Liabilities**

Mortgage	_____
Loans	_____
Other Liabilities	_____
Total Liabilities:	_____

Has Applicant given away any assets within the past 60 months? ( ) Yes ( ) No  
 Date(s) of asset transfer(s): \_\_\_\_\_

\*\*\*\*\*  
 TO THE BEST OF MY KNOWLEDGE AND BELIEF, ALL OF THE ABOVE INFORMATION IS ACCURATE AND TRUE. I ALSO WARRANT THAT THE INFORMATION PROVIDED CONCERNING THE APPLICANT'S FINANCES IS TRUE, CORRECT, COMPLETE AND ACCURATE IN ALL MATERIAL RESPECTS AND THAT THERE ARE NO MATERIAL OMISSIONS.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

THIS FACILITY DOES NOT DISCRIMINATE IN ADMISSION OR RETENTION OR CARE OF ITS RESIDENTS BECAUSE OF RACE, CREED, COLOR, NATIONAL ORIGIN, SEX, DISABILITY, AGE, SOURCE OF PAYMENT, MARITAL STATUS, OR SEXUAL PREFERENCE.