Apostolic Christian Home of Roanoke
Application for Admission*

FOR OFFICE USE ONLY:

RES. #_____ ADM. DATE_____ UNIT/ROOM/BED_____

PAYER SOURCE: MEDICARE_____ MEDICARE ADVANTAGE_____ PRIVATE PAY_____ MEDICAID_____

ADMITTED FROM: HOME_____ HOSP/SNF:_____ OTHER:_____

QHS:_____ DAYS USED:_____

DR:_____ CODE STATUS: _____

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Application for: Skilled Nursing Home: _____ Country View Apartments: _____

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*****Please complete all sections to be considered for admission. Do not leave any spaces blank.*****

_____ _____ _____

Last name (List name as it appears on your Medicare card) First name Middle

Preferred Name:_____

_____ _____

Current Street Address, City, State, & Zip Area Code & Phone

Are You a Veteran?: Y__ N__ Is your spouse?: Y__ N__ If yes, list claim number:_____

Birthplace:_____ Lifetime Occupation:_____

Soc.Sec.#:__ __ __ - __ __ - __ __ __ __ **Sex**: Male____ Female_____ **Birth date**: _____

Race: Caucasian: ____ African/American:____ Other: ____ **Marital Status**: S__ M__ W__ D__

Spouse's Name:_____

Mother's Maiden Name:_____

Father's Name: _____

Do you have a Power of Attorney for Healthcare? NO____ YES_____ Name: _____

Do you have a Power of Attorney for Property/ Finance? NO____ YES ____ Name:_____

***Revised 9/19/12**

INSURANCE INFORMATION:
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Medicare Part A

Medicare #:

__ __ __ __ - __ __ __ - __ __ __ __

Name of Medicare Supplement Insurance Co.:

_____

Policy #: _____

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OR

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Medicare Part C

Replacement Insurance for Medicare (HMO/PPO)

Humana: _____

Blue Cross/Blue Shield: ____

Secure Horizons: _____

Other: _____

Policy #:_____

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EMERGENCY CONTACT INFORMATION:
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Note: First contact must be Healthcare POA.

Please specify which phone number you prefer be listed first.

1.) Name: _____

Address: _____

City: _____

State and Zip: _____, _____

Home phone: (_____) _____

Work phone: (_____) _____

Cell phone: (_____)_____

E-mail:_____

Relationship: _____

For non-emergencies: Text____ Call_____

2.) Name: _____

Address: _____

City: _____

State and Zip: _____, _____

Home phone: (_____) _____

Work phone: (_____) _____

Cell phone: (_____)_____

E-mail:_____

Relationship: _____

For non-emergencies: Text____ Call_____

BILLING:

Who would you like the bill sent to?: _____ Relationship:_____

Address:_____ Phone: (_____) _____

Are you approved for Medicaid (Public Aid) Assistance: NO ____ YES ____
If so, please provide a copy, (both sides), of your Medicaid card with your application.

In the past, have you ever assigned your Medicare benefits to Medicare Part C, an HMO, PPO or to a Private Managed Care Ins. Company? NO_____ YES_____ Name of Group:_____

Do you have Medicare D (drug) coverage? NO _____ YES_____

Do you have any Long Term Care Insurance? NO _____ YES _____

Name of Company: _____ Policy #: _____

HISTORY:

List all hospitalizations in the last 60 days (please list hospital name AND dates):
_____
_____

Have you been in a nursing home in the past 60 days?: NO _____ YES ____
If so, where ?: _____

Have you received Home Health services in the last year?: NO____ YES____
If so, through what company? : _____

Have you previously been a resident of this facility? NO ____YES_____

Have you ever been convicted of a felony? NO_____ YES_____

Who is your primary family physician?: _____

Current specialist (Such as an orthopedic dr., cardiologist etc.): _____
(Please list full name & specialty)

Dentist:_____

Podiatrist:_____

Funeral Home preference: _____ City & State_____

Hospital preference: _____ City & State_____

Name of Church : _____Clergy: _____

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Person completing form: _____ Date:_____

Phone number:_____ Relationship: _____

PLEASE SEND IN OR BRING WITH YOU:

1.) **A LEGIBLE COPY OR ORIGINAL MEDICARE OR MEDICARE REPLACEMENT INSURANCE CARD**
2.) **A LEGIBLE COPY OR ORIGINAL SOCIAL SECURITY CARD**
3.) **A LEGIBLE COPY OR ORIGINAL OF THE SUPPLEMENTAL INSURANCE CARD (FRONT & BACK IF MAKING A PHOTO COPY)**
4.) **A LEGIBLE COPY OR ORIGINAL MEDICARE D (RX) INSURANCE CARD (FRONT & BACK IF MAKING A PHOTO COPY)**
5.) **ANY COPIES OF HEALTH CARE & PROPERTY POWER OF ATTORNEY PAPERS, GUARDIANSHIP PAPERS, OR LIVING WILL PAPERS IF APPLICABLE.**

Apostolic Christian Home of Roanoke
Resident Financial Information

The following information is confidential and will only be used in relation to the possible admission of this person to the Apostolic Christian Home of Roanoke. The Apostolic Christian Home of Roanoke has no expectation of financial contribution from this person other than the payment of his own bill. Personal finances will not be the only criteria affecting admission.

Monthly income amounts

Social Security: $_____ Pension: $_____ Interest: $_____

Rent Income: $_____ Other: $_____ **TOTAL:** $_____

Do you receive Supplemental Security Income (SSI)? Yes_____ No_____

Assets

Real estate (in whose name?): _____ Value: $_____

Savings: $_____ CDs: $_____ Checking: $_____

Cash: $_____ Stocks/bonds: $_____ **TOTAL:** $_____

Life Insurance: YES___ NO___ Does it have a cash value? YES _____ NO _____

Debts

Outstanding debt: $_____ Liens/Mortgages: $_____**TOTAL:** $_____

Other

Prepaid burial? Yes___ No___ If yes, list funeral home: _____

****

To the best of knowledge the financial information listed above is accurate, including all known assets

available to pay for the long term care of _____ as of _____.
(Name) (Date)

Signature: _____ ***Relationship:*** _____