

**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: \_\_\_\_\_

=====

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

Name: \_\_\_\_\_

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**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

1.) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State and Zip: \_\_\_\_\_, \_\_\_\_\_

Home phone: (\_\_\_\_\_) \_\_\_\_\_

Work phone: (\_\_\_\_\_) \_\_\_\_\_

Cell phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_

2.) Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_

State and Zip: \_\_\_\_\_, \_\_\_\_\_

Home phone: (\_\_\_\_\_) \_\_\_\_\_

Work phone: (\_\_\_\_\_) \_\_\_\_\_

Cell phone: (\_\_\_\_\_) \_\_\_\_\_

Relationship: \_\_\_\_\_

**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 #: \_\_\_\_\_

Name: \_\_\_\_\_

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## HISTORY:

List all hospitalizations in the last 60 days:

\_\_\_\_\_  
\_\_\_\_\_

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: \_\_\_\_\_

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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:** \_\_\_\_\_