Apostolic Christian Home
OF ROANOKE

Application for Admission

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: _____ 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:_____

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:_____

INSURANCE INFORMATION:
****

Medicare Part A

Medicare #:

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

Name of Medicare Supplement Insurance Co.:

_____

Policy #: _____

****

OR

****

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:
****

Note: First contact must be Healthcare POA

1.) Name: _____

Address: _____

City: _____

State and Zip: _____, _____

Home phone: (_____)

_____

Work phone: (_____) _____

Cell phone: (_____)_____

E-mail:_____

Relationship: _____

2.) Name: _____

Address: _____

City: _____

State and Zip: _____, _____

Home phone: (_____) _____

Work phone: (_____) _____

Cell phone: (_____)_____

E-Mail: _____

Relationship: _____

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.**

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: $_____

Have any assets been transferred to an asset protection trust: Yes_____ No_____

If so, what is the value of these assets available to cover cost of care $_____

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: _____

APPLICANT'S STATEMENT: According to my best knowledge, the foregoing information is complete, accurate and true and **THESE ASSETS ARE AVAILABLE AND WOULD BE USED FOR MY CARE AT THE APOSTOLIC CHRISTIAN HOME OF ROANOKE (ACHR**). I certify that answers given herein are true and complete to the best of my knowledge. I authorize verification of all statements contained in this application for admission as may be necessary in arriving at an admission decision, including, but not limited to, medical records from hospitals and other facilities and financial records. Additionally, I will cooperate in the preparation, filing, signing and processing of necessary applications, reports, or documents for any private or governmental financial assistance program in a timely manner. ACHR may release medical/billing information for purposes of claiming insurance benefits. I understand that this application is not intended to be a contract for care. NOTE: This application can be processed only when fully completed.

X_____ _____

Signature of Applicant or Representative (indicate relationship) **(Date)**

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: _____