Admissions Application

Patient's Name____

Current Address____

Birth Date ___________________________Sex ____________ Marital Status ___________________

Birth Place____________________________________Religion______________________________

Education/Degree______________________________Previous Occupation______________________

Spouse's Name____

Father' Name______________________________ Mother's Maiden Name_____________________

Social Security Number_______________________________ Medicare Number__________________

Other Health Insurance_________________________________Number________________________

Personal laundry (check one) Facility __________________________ Family _____________________

Funeral Arrangements____

Will patient be Medicaid Eligible within 6 Months? Yes or No_________________________________

DSS Office__________ Eligibility Worker________________ Medicaid Number _________________

Point of Contact's Address____

Relationship to the Patient____

Point of Contact's Address____

Home Phone________________________________ Work Phone___________________________

Power of Attorney? Yes ☐ No ☐

Does Patient have a Living Will or Advance Directive? Yes ☐ No ☐

Second person to notify in case of emergency____

Relationship to the Patient____

Home _____________________________________ Work Phone____________________________

Patient now at: Home_________ Adult Home__________ Nursing Home__________ Hospital_________

Other____

Name of Hospital or Facility ____

Social Worker ____

Patient's Physician____

How were you referred to Stoddard Baptist Nursing Home?_____________________________________

FINANCIAL APPLICATION

1. How long does the patient plan to reside at Stoddard Baptist Nursing Home?

____

2a. Names of persons who will be financially responsible for the patient's cost of care:

____

Name Address Home Phone Number

2b. Has a trust account been established or a power of attorney conferred on the persons to be financially responsible ☐ Yes ☐ No

2c. If "yes" please provide us with a copy of the trust document or the document granting power of attorney. If the trustee or the individual exercising the power of attorney is other than a person in (2a), please give his or her name.

____

Name Address Home Phone Number

____

Name Address Home Phone Number

3. Is the patient physically and/or mentally capable of handling his or her own affairs?
Yes ☐ No ☐

If not, has a guardian or committee been appointed? Yes ☐ No ☐

____

Name Address Home Phone Number

____

Name Address Home Phone Number

State the court in which he/she was appointed?

____

4. Please show the assets and sources of income available to help pay the cost of care:

(A) Real Estate

Location	Estimated Market Value	Annual Rental Income	Balance on Mortgage

(B) Checking Accounts:

Bank and Account Number	Current Balance

(C) Savings Account

Bank and Account Number	Current Balance

(D) Stocks, Bond, Securities

Name	Estimated Value	Annual Interest Dividends

(E) Pension, Annuities, IRA:

Name	Estimated Current Value	or	Monthly Income

(F) Social Security:
Monthly Benefit

____

(G) Insurance Policies:

Insurance Company	Beneficiary	Estimated Present Cash Vale

(H) Sources other than above:

____
____
____

(I)

Notes Due	$______________________________
Account	$______________________________
Loans Due	$______________________________
First or Second Trust Held	$______________________________

5. Has the patient transferred any assets over $5,000 in value, such as real estate, stocks, bonds or other assets to another person without consideration?

   In the last 24 months? ☐ Yes ☐ No (If yes, please explain)

   ____
   ____
   ____

6. Fill out if patient is on Medicare:

   Do you plan to have the patient remain in the nursing home after Medicare benefits are exhausted? ☐ Yes ☐ No (If no, where will the patient go?)

   ____
   ____
   ____

7. Have you or anyone in the past two years made application for this person to be on Medicaid?

   ☐ Yes ☐ No (If yes, please explain)

   ____
   ____
   ____

   Have you filed an appeal? ☐ Yes ☐ No Date:____________________________

***Incorrect information on this application can result in the potential client being ineligible for Medicaid.**

____ _________________________________

Name of Person Completing Application Patient

____

Date

Rate Schedule
Effective May 1, 2020

Room, Board and Routine Nursing Care	
Intermediate/Skilled	**$360.00 per day**
Physical Therapy	
Evaluation	$65.00 per unit (15 minutes)
Treatment	$65.00 per unit (15 minutes)
Occupational Therapy	
Evaluation	$65.00 per unit (15 minutes)
Treatment	$65.00 per unit (15 minutes)
Speech Therapy	
Evaluation	$65.00 per unit (15 minutes)
Treatment	$65.00 per unit (15 minutes)
Clinitron Bed and Supplies	$250.00 per day
Mattress overlay	$25.00 per day
Pharmaceuticals	Billed as used + 10%
Medical Supplies	Billed as used + 10%
Transportation	
Wheel chair van	$75.00 - $100.00
Taxi	$35.00
Escort Fee	$25.00

FINANCIAL ITEMS/DOCUMENTATION NECESSARY FOR ADMISSIONS

Dear Applicant:

In order for you to be approved financially, please provide the Admissions Department with the following items and documentation below that applicable.

Statement/Verification of Income:

- ☐ Bank or other asset statements covering the past month.
- ☐ Social Security Administration
- ☐ Supplemental Security Income
- ☐ Veterans Administration
- ☐ Civil Service Administration
- ☐ Pension or Other Retirement

Verification of Insurance

- ☐ Social Security Status Report
- ☐ Medicare Card (not copy)
- ☐ Medicaid Card
- ☐ Social Security Card
- ☐ Birth Certificate
- ☐ Blue Cross Blue Shield Card
- ☐ Aetna Card
- ☐ Long Term Care Policy
- ☐ Life Insurance Policy
- ☐ Other Insurance Information:____
- ☐ Funeral and Burial Pre-Arrangement (if applicable)
- ☐ Current Statement of Burial Account (if applicable)
- ☐ Documents of Life Insurance for funeral and burial
- ☐ Property____
- ☐ Other
  ____

Other Information
____

____