Stoddard Baptist NURSING HOME

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

Stoddard Baptist NURSING HOME

Rate Schedule
Effective May 1, 2022

Room, Board and Routine Nursing Care	
Intermediate/Skilled	**$450.00 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

_____

_____