



Nursing Center and/or Personal Care Admission Application

Please Check One: Short-term care/rehabilitation Long-term care

Name of Applicant _____ Date of Birth _____

Address _____ Phone _____

City, State, Zip _____

Marital Status _____ SSN _____ Male _____ Female _____

Medicare # _____

Blue Cross No. _____ Blue Shield No. _____ Group No. _____

HMO Provider _____ ID No. _____ Group No. _____

Other Insurance _____ ID No. _____ Group No. _____

For what level of care are you applying? Personal Care Nursing Alzheimer's Special Care

Emergency Contact Name _____ Relationship _____

Address _____ Phone _____

City, State, Zip _____ Email _____

Bus. Phone _____ Cell Phone _____

Will you consent to have your physician release information to Baptist Homes regarding your health and medical needs? yes no

Do you have a living will? yes no

Are you a veteran or otherwise eligible for Veteran's benefits? yes no

Your hospital preference: _____ Primary Care Doctor _____

Church affiliation: _____ Phone No. _____

Funeral Home: _____ Phone No. _____

Do you have a pre-paid burial? yes no If so, value: \$ _____

Have you made any organ donation decisions? yes no

If yes, please specify: _____

In the event we cannot reach you, please list a family member or friend who may be contacted on your behalf:

Additional Contact Name _____ Relationship _____

Address _____ Phone _____

City, State, Zip _____ Email _____

Bus. Phone _____ Cell Phone _____

Financial Information

Monthly Income:

Pension	\$	_____
Investment Income	\$	_____
Social Security	\$	_____
Other	\$	_____
SSI	\$	_____

TOTAL MONTHLY INCOME \$ _____

Value of personal assets, not including real estate:

Savings Account	\$	_____
Checking Account	\$	_____
Stocks & Bonds	\$	_____
Trust Funds	\$	_____
Surrender value of life insurance	\$	_____
Other	\$	_____

TOTAL LIQUID ASSETS \$ _____

Value of solely or jointly owned real estate, to your best estimate: \$ _____

Will the sale of this real estate be used to pay for your care? yes no

Is anyone other than yourself legally authorized to handle your financial and/or personal matters?

yes no

If yes, please explain (power of attorney, guardian, etc.)

Name _____ Relationship _____

Address _____ Phone _____

City, State, Zip _____ Business Phone _____

Who should receive billing statements if you become a Baptist Homes resident? Self Other (please list:)

Name _____ Relationship _____

Address _____ Phone _____

City, State, Zip _____ Email _____

Bus. Phone _____ Cell Phone _____

Signature of Applicant/Preparer _____ Date _____

This form does not create any contractual obligation between the applicant and Baptist Homes, nor does this form bind either party to admission.

Baptist Homes complies with the provisions of the Federal Civil Rights Act of 1964 and the Pennsylvania Human Relations Act, and affirms that no person shall, on the grounds of race, color, national origin, religious creed, ancestry, age, sex or handicap, be excluded from participation in or the benefits of any service or care.

NOTE: Baptist Homes is designated a smoke-free campus.

