



**BAPTIST HEALTH**  
**NURSING AND REHABILITATION CENTER**

297 No. Ballston Ave  
 Scotia, New York 12302  
 (518) 370-4700 - Fax (518) 370-0371

How did you hear about us? \_\_\_\_\_

**LONG TERM CARE  
 PRE-ADMISSION INFORMATION**

**I. GENERAL INFORMATION**

DATE: \_\_\_\_\_

PATIENT'S NAME: \_\_\_\_\_  
 LAST: \_\_\_\_\_ FIRST: \_\_\_\_\_ INITIAL: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE/ZIP: \_\_\_\_\_

PATIENT'S PRESENT LOCATION (if different than home address):

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE/ZIP: \_\_\_\_\_

PERSON REPRESENTING PATIENT: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY: \_\_\_\_\_ STATE/ZIP: \_\_\_\_\_

PHONE NO.: \_\_\_\_\_

STATUS: (Please check appropriate response)       POWER OF ATTORNEY       CONSERVATOR  
 PERSON RESPONSIBLE FOR HANDLING FINANCIAL TRANSACTIONS

PATIENT'S MARITAL STATUS:     SINGLE     MARRIED     WIDOWED     SEPARATED     DIVORCED

MEDICAID APPLICATION PENDING:       YES     NO    IF YES, DATE SUBMITTED: \_\_\_\_/\_\_\_\_/\_\_\_\_

PRIMARY PHYSICIAN: \_\_\_\_\_ U.S. CITIZEN     YES     NO

**II. FINANCIAL DISCLOSURE (Information is considered confidential)**

INCOME	MONTHLY AMOUNT
SOCIAL SECURITY	\$ _____
RETIREMENT PENSION	\$ _____
VETERAN'S PENSION	\$ _____
RAILROAD PENSION	\$ _____
SUPPLEMENTARY SECURITY INCOME	\$ _____
ANNUITIES	\$ _____
OTHER INCOME	\$ _____
TOTAL MONTHLY INCOME	\$ _____