Baptist Health Nursing and Rehabilitation Center
297 North Ballston Ave, Scotia, NY 12302
Phone (518) 370-4700 Fax (518) 370-0371

Admission Application

Name _____ Date _____
Current Address _____
City _____ State _____ Zip _____
County _____ Phone # _____
DOB _____ Social Security # _____
Medicare # _____ Part A: Yes No Part B: Yes No
Other Insurance _____ ID # _____
Medicaid # _____ Effective Date _____ Medicaid County _____
Medicaid Application Submitted? Yes No Date Submitted: _____
US Military Service: Yes No Branch _____ from _____ to _____
Marital Status: Single Married Widowed Divorced Separated
Name of Spouse _____
If deceased, date _____

Personal Contacts

1. Name _____Relationship _____
   Address _____
   Home Phone _____ Cell _____ Work _____

2. Name _____Relationship _____
   Address _____
   Home Phone _____ Cell _____ Work _____

3. Name _____Relationship _____
   Address _____
   Home Phone _____ Cell _____ Work _____

Advanced Directives

Power of Attorney Yes No (if yes please attach copy)
Name(s)_____

Health Care Proxy Yes No (if yes please attach copy)
Name(s)_____

Are you working with an Elder Law or similar Attorney? Yes No
Name _____ Phone # _____

Funeral Parlor _____ Phone # _____
Address _____

Arrangements for organ donation / anatomical gift Yes No (if yes, please attach copy)

Financial Assets and Income

1. Bank Accounts

A. Bank _____ Type of Account _____
Balance $_____ Names on Account_____
B. Bank _____ Type of Account_____
Balance $_____ Names on Account_____
C. Bank _____ Type of Account _____
Balance $_____ Names on Account_____
D. Investment _____ Market Value $ _____
Names on Account _____
E. Investment _____ Market Value $ _____
Names on Account _____

2. Within the past 60 months, have you **transferred** any assets or property to family or friends?
Yes No If yes, provide dollar amount and date of transfer.
Amount/Value: _____ Date: _____ Amount/Value: _____ Date: _____
Amount/Value: _____ Date: _____ Amount/Value: _____ Date: _____

3. Within the past 60 months, have you entered into any **"TRUST"** arrangements?
Yes No If yes, list value of assets involved and date of transfer. Also provide a copy of the Trust.
Value: _____ Date: _____ Value: _____ Date: _____
Value: _____ Date: _____ Value: _____ Date: _____

4. Do you own property? Yes No
A. Type of property: Primary Residence Rental Vacation Commercial
Estimated Value $_____ Is it jointly owned? Yes No
Property Owners: _____
B. Type of property: Primary Residence Rental Vacation Commercial
Estimated Value $_____ Is it jointly owned? Yes No
Property Owners: _____

5. I own life insurance: Yes No
A. Name of Insurance Company _____ Policy _____
Cash surrender value $ _____
B. Name of Insurance Company _____ Policy _____
Cash surrender value $ _____

6. I own Stocks and/or Bonds: Yes No
Name of Investment: _____ Market Value: $_____
Name of Investment: _____ Market Value: $_____

7. Do you have Long Term Care Insurance? Yes No
Name of Carrier: _____ Monthly Payment $_____

Income Per Month

1. Social Security	$ _____	
2. Pensions		
a. Government	$_____	ID _____
b. VA Pension	$ _____	ID _____
c. Company	$ _____	Name of Company _____
d. Other	$ _____	Describe _____
3. Interest Income	$ _____	Describe _____
4. Trust Income	$ _____	Describe _____
5. Other Income	$ _____	Describe _____

Total Monthly Income $ _____

Hospital Preference: _____

Community Physician: _____ Phone #: _____

Previous skilled nursing/rehab admissions?

Dates: _____ to _____ Facility: _____
Dates: _____ to _____ Facility: _____
Dates: _____ to _____ Facility: _____

To the best of my knowledge, all of the information provided herein is correct and valid.

_____ _____
Signature of Resident or Responsible Party Date

Please mail or fax application to Baptist Health Systems.

The information provided shall remain confidential and shall be made available only to authorized personnel involved in the placement process and to any government officials authorized access by law to such records.

The facilities having access to this information do so without regard to race, creed, color, age, sex, religion, national origin, sponsor, sexual preference, disability, or marital status. Persons under the age of 16 years of age are not eligible for admission consideration, unless special approval has been received from the department of health.