## 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		Sta	ateZip	)	
City County		Phone #	1		
DOB	Social Security #				
Medicare #	Part A:	Yes No	Part B:	Yes No	
Other Insurance			ID #		
Medicaid #	Effective Date		Medicaid Count	<u> </u>	
Medicaid Application Subr	nitted? Yes N	o Date Su	ıbmitted:		
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		
	Gen		WOIN		
2. Name			Relationship		
Address			-		
Home Phone	Cell		Work		
2 Name			Dolotio moleim		
3. Name			_		
Address Home Phone	Coll		Worls		
nome mone	Cell		WOIK		
Advanced Directives					
Power of Attorney Yes	No (if yes please at	ttach copy)			
Name(s)					
11 11 C D V	NI	, 1			
Health Care Proxy Yes	No (ii yes piease at	tach copy)			
Name(s)					
Are you working with an I	Elder Law or similar A	Attorney? Y	es No		
Name					
			<del>_</del>		
Funeral Parlor		Phone #			

## Financial Assets and Income

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	1. Bank Accounts	
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 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: 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:  B. 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:  B. 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:  B. Name of Insurance: Yes No No Market Value: \$ No Name of Investment: Market Value: \$ Market Value: \$ Name of Investment: Market Value: \$ Market Value: \$ Name of Investment: Mark	A. Bank	Type of Account
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Estimated Value \$		
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7. Do you have Long Term Care Insurance? Yes No		
,	Name of Investment:	Market Value: \$
,		2 77 27
NT CC '	7. Do you have Long Term Care Insura	ance: Yes No

## **Income Per Month**

1. Social Security	\$	<u></u>	
2. Pensions			
a. Government	\$	ID	
b. VA Pension	\$	TD.	
c. Company	\$		
d. Other	\$		
3. Interest Income	\$	Describe	
4. Trust Income	\$	Describe	
5. Other Income	\$		
	Total	Monthly Income \$	
Hospital Preference:			
Community Physician: _		Phone #:	
Previous skilled nursing/	rehab admissions?		
Dates: to	Facility:		
Dates: to	Facility:		
To the best of my knowledge of the best of my knowledge.	edge, 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.