

LAKESIDE BEIKIRCH CARE CENTER

Application for Short-Term Admission

IDENTIFYING INFORMATION:

Patient Name: _____	Date of Birth: _____
Home Address: _____	SSN#: _____
County: _____	Telephone: _____
Marital Status: S M W D	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
Family MD: _____	DNR: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Health Care Proxy: <input type="checkbox"/> Yes <input type="checkbox"/> No

CONTACT INFORMATION (Please list in the order you wish to be contacted):

Contact Name: _____	Relationship: _____
Address: _____	Home Phone: _____
	Work Phone: _____
<input type="checkbox"/> Power of Attorney <input type="checkbox"/> Healthcare Agent	
Name: _____	Relationship: _____
Address: _____	Home Phone: _____
	Work Phone: _____
<input type="checkbox"/> Power of Attorney <input type="checkbox"/> Healthcare Agent	

PERSONAL FINANCIAL INFORMATION:

HOUSEHOLD MONTHLY INCOME:		HOUSEHOLD ASSETS/RESOURCES:	
	Applicant	Spouse	
Social Security Retirement:			Individual
Social Security Disability:			Joint
Pension (Specify):			Checking: _____
Wages:			Savings: _____
Other Income (specify):			Money Market: _____
			Certificate of Deposit: _____
			Stocks, Bonds Annuities: _____
			IRA/Keogh Accts: _____
			Trust Funds: _____
			Property: _____
			Life Ins. Cash Value: _____

House? Yes No
 Spouse, Disabled Adult, Child in Home? Yes No
 Transfer of funds within last 36 months? Yes No
 If yes, state amount and reason for transfer: _____

INSURANCE INFORMATION (include policy and telephone numbers for no-fault/commercial insurances):

Medicare: _____	Medicare Blue Choice: _____
Medicaid CIN: _____	Blue Choice Senior: _____
Medicaid Case Worker: _____	Blue Choice: _____
Blue Cross: _____	Preferred Care Gold: _____
Kodak Extended Care: <input type="checkbox"/> Yes <input type="checkbox"/> No	Preferred Care: _____
No Fault: _____	Via Health: _____
Contact: _____ Phone: _____	Long Term Care Insurance: _____
Commercial: _____	
Contact: _____ Phone: _____	

HAS THERE BEEN ANY HOSPITAL/NURSING HOME STAYS IN THE PAST 60 DAYS? YES NO

IF YES, NAME OF FACILITY: _____ **DATES OF STAY:** _____
COMPLETED BY (please print): _____ **SIGNATURE:** _____
RELATIONSHIP TO PATIENT: _____ **DATE:** _____