St. Peter's Health Partners

PRE – ADMISSION UNIVERSAL APPLICATION

Present Location: ______________________________

I. GENERAL INFORMATION Date: ______________________

PATIENT INFORMATION:

Last: ______________________ First: ______________ Initial: _______

Address: ______________________________

City: ______________________ State/Zip: ______________

II. INSURANCE INFORMATION

Medicare: ______________________________

Other Insurance: ______________________________

Medicaid Application Pending: ☐ YES ☐ NO If Yes, Date Submitted: __________ County: __________

Name and Relationship of Individual Representing Patient: ______________________

Address: ______________________________

City: ______________________ State/Zip: ______________

Telephone: ______________________ Work/Cell Phone: ______________

Status: (Please Check) ☐ Power of Attorney ☐ Legal Guardian ☐ Health Care Proxy
☐ Person Responsible for handling Financial Transactions

Patient's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
U.S. Citizen: ☐ Yes ☐ No

Primary Physician:

Name: ______________________ Phone: ______________

III. FINANCIAL DISCLOSURE (All information is kept confidential)

INCOME	MONTHLY AMOUNT (For Applicant)	MONTHLY AMOUNT (For Spouse if applicable)
Social Security	$________	$________
Retirement Pension	$________	$________
Veteran's Pension	$________	$________
Railroad Pension	$________	$________
Supplementary Security Income	$________	$________
Annuities	$________	$________
Other Income	$________	$________
Total Combined Monthly Income	$________	

ASSETS

CHECKING ACCOUNTS:
Bank Name: ______________________________

Account Balance $________________ Joint Account: ☐ Yes ☐ No

SAVINGS ACCOUNTS:
Bank Name: ______________________________

Account Balance $________________ Joint Account: ☐ Yes ☐ No

OTHER ACCOUNTS:
Bank Name: ______________________________

Account Balance $________________ Joint Account: ☐ Yes ☐ No

Certificates of Deposit:

Bank Institution: ________________ Balance: $__________

Does the patient own a home: ☐ Yes ☐ No Estimated Value: $______________

If yes, is the home jointly owned with anyone? ______________________

Does the patient have Long Term Care Insurance: ☐ Yes ☐ No

If yes, which Insurance Company______________________________

Other Assets (e.g. stocks, bonds, other) (Please list)	Amount
1. ______________________	$______________
2. ______________________	$______________
3. ______________________	$______________

Have any assets been transferred in the last 60 months: ☐ Yes ☐ No
If yes, please describe: ______________________________

____

Has an Estate or Family Trust been established: ☐ Yes ☐ No If yes, when ______ please provide copy
Date

To the best of my knowledge, all the information provided is correct and valid. I understand that the information contained in this form will be shared with nursing homes.

X______________________ ______________________
Signature of Patient or Responsible Party Date

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

The facilities having access to the information do so without regard to race, creed, color, age, sex, religion, national origin, sponsor, sexual preference, disability or criminal status. Persons under 18 years of age are not eligible for admission consideration unless special approval has been received from the Department of Health.