

Ent. Info Date _____ Room/Apt # _____ Adm#: _____

RESIDENT ADMISSION APPLICATION

Apartment/Independent Living Healthcare/Nursing Memory Unit

Applications are reviewed without regard to race, color, national origin, sex, disability, religion, or political affiliation.

How did you hear about us? Billboard Radio Newspaper Friend _____

Other _____

Preferred Move-In Timeframe: Immediately 1-3 months 3-6 months 6+ mo./Planning Ahead

Applicant Information

Status: Married Single Widow Widower Divorced

Prefix Preference: Ms. Mrs. Mr. Sex: Male Female U.S. Citizen: Yes No

Name: _____ SS#: _____

Address: _____ City: _____ State: _____ ZIP: _____

Resident at this address, how long? _____

Present Living Arrangements: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Birthplace: _____

Veteran: Yes No Branch of Service: _____ VA #: _____

Spouse of Veteran: Yes No Branch of Service: _____ VA #: _____

Education: Elementary High School College/University Masters Doctoral

Previous Occupation(s): _____

Spouse Name: _____

Date of Marriage: _____ Location: _____

If spouse is deceased, date of death _____

Spouse Previous Occupation(s): _____

Applicant's Mother's Name: _____

Applicant's Father's Name: _____

Religious Information

Religion: _____

Church/Temple: _____

Address: _____ City: _____ State: _____ ZIP: _____

Clergy Name: _____ Phone: _____

Medical Providers

Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Podiatrist: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Other/Specialist: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Dentist: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Optometrist/Ophthalmologist: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Preferred Hospital: MercyOne Medical Center UnityPoint Finley Hospital Other _____

Pharmacy Hartig Hy-Vee Mercy Target Walmart Walgreen's Other _____

*If your doctor authorizes that you may administer your own medications, you may get them from whomever you choose. If you need staff administration, we require unit dose which is available from Hartig's and Mercy Family Pharmacy only.

Insurance Information (as applicable)-Please attach copies of all insurance cards to application

Medicare No: _____ Effective Date: _____

Supplemental Insurance: _____ Policy #: _____

Part D (Prescription Insurance): _____ Policy #: _____

Medicare Advantage: _____ Policy #: _____

Medicaid MCO: _____ Policy #: _____

Long-Term Care Policy Name: _____ Policy #: _____

Billing & Emergency Contacts

Billing Contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Cell: _____ Work: _____

Email: _____

Check here to have bills emailed instead of mailed

Legal Authority: Conservator Guardian Medical POA Financial POA

Emergency Contact: _____ Relationship: _____

Address: _____ City: _____ State: _____ ZIP: _____

Phone: _____ Cell: _____

Work: _____ Email: _____

Spouses Name (if applicable): _____

Legal Authority: Conservator Guardian Medical POA Financial POA

End-of-Life Preferences

Cemetery Lot Owned: Yes No

Cemetery Name: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Funeral Home/Mortuary: _____ Phone: _____

Address: _____ City: _____ State: _____ ZIP: _____

Living Will: Yes No (if yes, please provide a copy of this document)

Durable Power of Attorney for Health Care: Yes No (if yes, please provide a copy of this document)

Lifestyle

Tobacco Use: Yes No (if yes, Cigar Cigarettes Pipe Other)

Alcohol Use: Yes No

Is there anything else you would like to share with us that will help us serve you better?

Immediate Family Members

Please list names, addresses, and phone numbers of all other immediate family members, please include spouse's name also in parenthesis if applicable (attach additional pages if needed)

Name: _____ (_____) Relationship: _____

Phone: _____ Cell: _____

Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Name: _____ (_____) Relationship: _____

Phone: _____ Cell: _____

Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Name: _____ (_____) Relationship: _____

Phone: _____ Cell: _____

Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Name: _____ (_____) Relationship: _____

Phone: _____ Cell: _____

Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Name: _____ (_____) Relationship: _____

Phone: _____ Cell: _____

Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Name: _____ (_____) Relationship: _____

Phone: _____ Cell: _____

Email: _____

Address: _____ City: _____ State: _____ ZIP: _____

Financial Information:

We may require current bank/financial statements for all info listed below

At the time of admission, if the assets have significantly changed, please let Bethany know so we are able to update the form and better assist you through this transition.

	Monthly	Annual
Pension	\$ _____	\$ _____
Military Pension (SBP; yes/no)	\$ _____	\$ _____
Social Security (applicant)	\$ _____	\$ _____
Social Security (spouse, if applicable)	\$ _____	\$ _____
Dividends & Interest (annual)	\$ _____	\$ _____
IRA or 401K	\$ _____	\$ _____
IRA or 401K (if multiple)	\$ _____	\$ _____
IRA or 401K (if multiple)	\$ _____	\$ _____
Other (specify) _____	\$ _____	\$ _____
Other (specify) _____	\$ _____	\$ _____
Total Income	\$ _____	\$ _____

I own the following Real Estate/Property:

Description of Property	\$ Net Value
1.) _____	\$ _____
2.) _____	\$ _____
3.) _____	\$ _____
Net Value of Property (value less any debt against it)	\$ _____

I have the following checking/savings/investment accounts:

Type of Account	Financial Institution	Amount
1.) _____	_____	\$ _____
2.) _____	_____	\$ _____
3.) _____	_____	\$ _____
4.) _____	_____	\$ _____
5.) _____	_____	\$ _____
Total Value of Checking/Savings/Investments		\$ _____

Health Requirement

Condition of Health: A completed personal health history form must accompany application.

A current (within three months of admission) medical examination by a licensed physician is required prior to entering Bethany Home. The pre-admission health form must be filled out by your attending physician.

Please ensure all personal items are clearly labeled with the resident’s name. This helps prevent loss, especially for items that are laundered. Clothing name tags may be ordered through Bethany. Hearing aids, dentures, partial plates, eyeglasses, etc., must also be marked.

According to the best knowledge and belief, the foregoing information is complete, accurate and true in all respects. I understand that the accuracy of the above financial report is one of the conditions of my acceptance at Bethany Home and that the total resources listed on my application are available as needed for my personal care at Bethany Home.

I understand that a personal health history will need to be completed before admission to Bethany Home.

I certify that the information provided is accurate and complete.

Applicant or Responsible Party Signature: _____ Date: _____

Witness Signature: _____ Date: _____