BETHANY+VILLAGE

THE ART OF LIVING

Bethany Home Application for Admission

Phone: 785-227-2334 Ext. 145 / Fax: 785-227-9950

Email: CDeines@bethanyhome.com **Website:** www.BethanyVillageKS.com

Resident Name: _____
Last First Middle

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Telephone: (_____)_____ **Date of Birth:** _____ **Age:** _____ **Sex:** F / M

Living arrangements (circle one): Living Alone / Spouse/Partner / Facility Other: _____

Marital Status (circle one): Single / Married / Widowed / Divorced / Separated / Other: _____

Are you an active smoker? Y / N

Name of Spouse/Partner: _____ **Anniversary Date:** _____

Former Occupation: _____ **Place of Birth:** _____

Military Service Branch: _____ **Dates of service:** _____

How did you hear about Bethany Home? Newspaper Radio Previous Family Member Other: _____

PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY OR STATUS CHANGE (Attach additional pages as necessary):
(Minimum of two contacts; one living in the immediate area)

Durable Power of Attorney for Health and Medical Decisions:

1. _____
Last Name, First Name Relationship Address City, ST Zip

_____
Phone / Cell Phone Email Address

Durable Power of Attorney for Financial Decisions:

2. _____
Last Name, First Name Relationship Address City, ST Zip

_____
Phone / Cell Phone Email Address

3. _____
Last Name, First Name Relationship Address City, ST Zip

_____
Phone / Cell Phone Email Address

4. _____
Last Name, First Name Relationship Address City, ST Zip

_____
Phone / Cell Phone Email Address

Church Affiliation: Baptist / Catholic / Covenant / Lutheran / Methodist / Other: _____

Name of Church: _____ **Address/City:** _____

Name of Pastor: _____ **Phone:** _____

Funeral Home: _____ **Address/City:** _____

Advanced Directives / Living Will (circle one):

YES I have one / **NO** I do not have one / I am interested in a living will/advanced directives

Billing / Financial Information:

Responsible Party: _____ **Relationship:** _____

Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Phone: (_____)_____ **Email Address:** _____

***** Please attach a copy of ALL cards*****

Social Security No.: _____ **Veteran Benefits:** _____

Medicare No.: _____ **Medicare D (Pharmacy) Ins:** _____

Health Ins.: _____ **Nursing Home Ins.:** _____

Title XIX (Medicaid) Assistance No.: _____

Medical Information:

Eye Glasses: Yes No **Hearing Aids:** Yes No **Dentures:** Yes No

Physician: _____ **Phone:** (_____)_____

Address: _____

Preferred Pharmacy: _____ **Phone:** (_____)_____

Dentist: _____ **Phone:** (_____)_____

Address: _____

Ophthalmology/Optometrist: _____ **Phone:** (_____)_____

Address: _____

All information contained in the application requires complete answers and remains the confidential property of Bethany Home Association. This preliminary information is required so that accurate evaluations may be made. We reserve the right to make room adjustments as deemed necessary. Bethany Home residents and families will be consulted before changes.

If admitted, I agree to cooperate with making life at Bethany Home pleasant and agreeable, and to comply with the Rules and Regulations of the facility. I declare the answers to the foregoing questions to be true, full, and correct to the best of my knowledge.

Name of person completing form (if different from resident): _____

Phone: (_____)_____ **Email Address:** _____

Signature of Applicant _____ **Date** _____

Signature of DPOA/Guardian_____ **Date** _____

Please return completed application with $40.00 application fee to:
Bethany Village, Admissions, 321 N. Chestnut, Lindsborg, KS 67456.
For questions or more information call 785-227-2334 Ext 145.

OFFICE USE ONLY:

Application Date _____ Approval Date _____

Application Fee ___$40.00_____ Waiting List: A _____ IA _____

Interview _____ Admissions Date _____

Comments: _____

Bethany Home Pre-Admission Financial Questionnaire

All Information provided will be held confidential

Regular Monthly Income:

	1st Person	2nd Person
Social Security	$	$
Pension	$	$
Dividends	$	$
Interest	$	$
Mortgage/Rental Income	$	$
IRA Income	$	$
Trust Income	$	$
Long Term Care Insurance	$	$
Other Income	$	$
Total Monthly Income	$	$

Capital Assets:

	1st Person	2nd Person
Cash (Savings & Checking)	$	$
CD's, Money Market, etc	$	$
Stocks and Bonds	$	$
IRA's, Annuities, etc	$	$
House	$	$
Other Real Estate	$	$
Trust Fund	$	$
Life Insurance	$	$
Pre-Paid Funeral Plan	$	$
Vehicle(s)	$	$
Total Assets	$	$

Are you a veteran or the spouse of a veteran? _____

5 Year Look Back (For Determining Medicaid Eligibility)

If an individual gives away money or property during the five-year look-back, it triggers a penalty period during which he or she is ineligible for government aid.

**This includes transfers of property that were in your name, house, autos, etc. either given away or for less than fair market value.

Have you given away any money or property during the past 5 years? Yes____ No____

Please provide the following documents:

If you have Long Term Care Insurance – Copy of Policy Schedule/Outline of Benefits

I hereby declare that all statements made herein are true according to my best knowledge and belief. Dated this _____day of _____20___.

_____

Resident's Name (Print)

_____ _____

Signature of 1st Person or DPOA Signature of 2nd Person or DPOA

Please return completed form to the Accounting Office