

# BETHANY+VILLAGE

THE ART OF LIVING

## Application for Admission

Bethany Home Long-Term Care/ Skilled Nursing

321 N. Chestnut, Lindsborg, KS

Phone: 785-227-2334 Ext. 144 / Fax: 785-227-9950

Morgan Coon, SSD

Email: [MCoon@bethanyhome.com](mailto:MCoon@bethanyhome.com)

Sunflower Terrace Assisted Living

821 E. Swensson, Lindsborg, KS

Phone: 785-227-8331 Ext. 200 / Fax: 785-227-8332

Kaitlynn Kennedy, RN, AL Operator

Email: [KKennedy@bethanyhome.com](mailto:KKennedy@bethanyhome.com)

Applicant is interested in being considered for:  Long Term Care  Skilled Nursing  
 Assisted Living (Apartment Preference:  Studio  1 Bdr  2Bdr)

Applicant Name: \_\_\_\_\_  
Last First Middle

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: F / M

Former Occupation: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Is applicant an active smoker? Y / N

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

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

Name of Spouse/Partner: \_\_\_\_\_ Anniversary Date: \_\_\_\_\_

Military Service Branch: \_\_\_\_\_ Dates of service: \_\_\_\_\_

How did you hear about Bethany Village? Google/Internet Previous Family Member Other: \_\_\_\_\_

**PERSONS TO BE NOTIFIED IN CASE OF EMERGENCY OR STATUS CHANGE** (Attach additional pages as necessary):

**Legal Durable Power of Attorney (DPOA) for Health and Finance is required for admission**

**Minimum of two contacts required**

1.  Medical DPOA  Financial DPOA  Guardian/Conservator  Responsible Party/Billing

\_\_\_\_\_  
Last Name, First Name Relationship

\_\_\_\_\_  
Address City, ST Zip

\_\_\_\_\_  
Phone / Cell Phone Email Address

2.  Medical DPOA  Financial DPOA  Guardian/Conservator  Responsible Party/Billing

\_\_\_\_\_  
Last Name, First Name Relationship

\_\_\_\_\_  
Address City, ST Zip

\_\_\_\_\_  
Phone / Cell Phone Email Address

3. \_\_\_\_\_  
Last Name, First Name Relationship Phone Email

4. \_\_\_\_\_  
Last Name, First Name Relationship Phone Email

**\*\*\* Please attach a copy of ALL Insurance and ID cards (front & back)\*\*\***

Social Security No.: \_\_\_\_\_ Medicare No.: \_\_\_\_\_

Other Medicare Plans: Are there other supplements/plans for the applicant?  Yes  No  I don't know

Medicare Advantage Plan: Does the applicant have an advantage plan?  Yes  No  I don't know

Long-Term Care Ins.: Does the applicant have other insurance?  Yes  No  I don't know

Title XIX (Medicaid) Assistance No.: \_\_\_\_\_

Veteran Benefits: Is the applicant eligible for veteran benefits?  Yes  No  I don't know

**Medical Information:**

Physician: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Ophthalmology/Optomestrist: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

Specialist/Other: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

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 :  Yes  No  I don't know  I would like more information

EMS Code Status:  DNR (Do Not Resuscitate)  Full Code (Perform CPR or other life saving methods)

All information contained in this 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.

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 Applicant): \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

Signature of Applicant/DPOA \_\_\_\_\_ 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 144.*

Application Date _____	<b>FOR OFFICE USE ONLY:</b>
Application Fee <u>\$40.00</u>	Approval Date _____
Interview _____	Waiting List: A _____ IA _____
Comments: _____	Admissions Date _____

# Bethany Village Pre-Admission Financial Questionnaire

All Information provided will be held confidential

**Regular Monthly Income:**

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

**Capital Assets:**

	1 <sup>st</sup> Person	2 <sup>nd</sup> 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)	\$	\$
<b>Total Assets</b>	\$	\$

**\*Is there a reverse mortgage on any of the property?**  Yes  No  I don't know

**Are you a veteran or the spouse of a veteran?**  Veteran  Spouse  Neither

I hereby declare that all statements made herein are true according to my best knowledge and belief.

\_\_\_\_\_  
**Resident's Name (Print)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
Signature of 1<sup>st</sup> Person or DPOA

\_\_\_\_\_  
Signature of 2<sup>nd</sup> Person or DPOA

*Please return completed financial questionnaires to Marilyn Spohn, Bethany Home, 321 N. Chestnut, Lindsborg, KS 67456. For questions or more information, call 785-227-2334 ext. 146.*