



APPLICATION FOR NURSING HOME ADMISSION

The following is an application for admission to our facility. Please complete this application, and return it to SCANDINAVIAN HOME to be considered for admission. Criteria for admission is the same for all persons without regard to race, gender, national origin, age, physical or mental impairments or financial resources.

Please complete the following:

Name: _____
(last) (first) (middle)

Social Security Number: _____ Sex: Female Male

Present Address: _____ Phone: (____) _____

City: _____ State: _____ Zip _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Marital Status: Married Divorced Widowed Single Separated

Spouse's Name: _____

How did you hear about this facility? _____

RELATIVES OR SIGNIFICANT OTHERS

Person to be notified in an emergency:

PRIMARY CONTACT

Name: _____ Home Phone: (____) _____

Relationship: _____ Work Phone: (____) _____

Address: _____ Cell Phone: (____) _____

City: _____ State: _____ Zip: _____

Email Address: _____

SECONDARY CONTACT

Name: _____ Home Phone: (____) _____

Relationship: _____ Work Phone: (____) _____

Address: _____ Cell Phone: (____) _____

City: _____ State: _____ Zip: _____

Email Address: _____

PRIMARY CARE PHYSICIAN

Physician's Name: _____

Office Phone: (____) _____ Office FAX: (____) _____

Date of last visit: _____ Will Physician follow in Nursing Home? Yes No

FINANCIAL/BILLING INFORMATION

HEALTH INSURANCE – Please check all that apply.

- Medicare
- Medicaid
- Managed Care
- Long Term Care Insurance

READINESS FOR PLACEMENT

The applicant is: (Please check yes or no for each question.)

- A. In immediate need for placement. Yes No
- B. Presently in the hospital. Yes No
- C. Living in the community. Yes No
- D. Planning ahead for possible future needs. Yes No

Hospitals utilized during the past 2 years:

Name: _____ Address: _____ Dates: _____

Reason: _____

Name: _____ Address: _____ Dates: _____

Reason: _____

Nursing Home or Rehab Facility utilized within the LAST year:

Name: _____ Address: _____ Dates: _____

Reason: _____

ADDITIONAL INFORMATION

By definition, a patient in Rhode Island is considered private paying until their individual assets are spent down to the R.I. Medicaid Eligibility Limit of \$4,000.00. Anyone who has less than \$4,000.00, upon application, would be eligible to apply for R.I. Medicaid Assistance through the R.I. Department of Human Services, prior to admission. In order for our home to project the Private Pay and Medicaid Census, we request your assistance in completing the following questions.

Based on the above criteria, you would be: (please check one)

- Private Pay
- Medicaid Eligible

A. If paying privately, at the rate of approximately \$ 300.00/day, you predict that you would remain private for approximately (**Indicate length of time**): _____

B. If there is a need for Medicaid Long Term Care Assistance, you have:

- Already applied with a decision of eligibility.
- Already applied with decision pending.
- Not begun application yet.
- A need to obtain further information regarding how to begin the decision process of Medicaid application.

Thank you for your interest in Scandinavian Home.