APPLICATION FOR ADMISSION

Thank you for choosing BayView Health Care!

Please check one of the following:

- ☐ BayView at Samantha R. Wilson
- ☐ Pavilion Assisted Living
- ☐ Buckingham Smith Assisted Living

Enclosed is the application for admission. Once this application is substantially complete and returned, a facility representative will be in contact with you to review your potential admission.

Required documents to be included:

- ☐ Copy of Insurance cards (including prescription drug plan)
- ☐ Current Advanced Directives
- ☐ Documents to verify assets (i.e. bank statements, etc.)
- ☐ Proof of Income

PERSONAL INFORMATION

Applicant's Name:____

Home/Previous Address:____

Present Location/Address:______________________________________

If medical facility, date of admission:_____________________________

Date of Birth________Age____Birthplace____________________Religion__________

Marital Status_______Previous Occupation__________Education________________

Hobbies/Interests(Past & Present)___________________________________

____

____Veteran(spouse of) Yes____No____

Veteran Service#________________Branch of Service_______________________

Primary Contact Person______________________Relationship__________________

Address____

Telephone: Days______________________Evenings___________________________

POA__________________Conservator: Person________________________________

(Please include documentation)

Other Involved Parties

Name_____________________________________Relationship_________________

Address____

Telephone: Days______________________Evenings___________________________

Name_____________________________________Relationship_________________

Address____

Telephone: Days______________________Evenings___________________________

MEDICAL INFORMATION

Name/Address of current physician___________________________________

____________________________________Phone #____________________________

Name/Addresses of all previous physicians and hospitalizations (and dates hospitalized)____

____

____

Is applicant receiving community services? If so, please list agencies & contact person.____

____

Reason placement is needed______________________________________

Attitude towards placement: Applicant__________________Family______________

Anticipated length of stay____

Diagnosis____

Medications ____

What assistance does applicant require with personal care (i.e.dressing, eating, walking, etc.)?____

____

Please list mental limitations or behavioral difficulties and successful management techniques.____

____

____

FINANCIAL INFORMATION

Social Security #_______________________Medicare #______________Part A______

Medicaid (State Assistance) #____

Does applicant have an application pending for State Medical Assistance (Title 19)?___

If yes, date application submitted___________

Managed Medicaid plan ____

Case Manager _______________________Case Worker Phone # _________________

Other Medical/Hospital Insurance:

Name of Company	Subscriber/Group #	Type of Insurance

Life Insurance (List only policies having a cash surrender value and give approximate cash surrender value:____

____

Has applicant established an irrevocable burial account?________________________

If so, name of funeral home and amount_____________________________________

INCOME

Social Security	$_________________/Mo		
Pensions	$_________________/Mo	Source	____________________________
VA Benefits	$_________________/Mo		
Annuities	$_________________/Mo	Source	____________________________
Interest	$_________________/Mo	Source	____________________________
Dividends	$_________________/Mo	Source	____________________________
Other	$_________________/Mo	Source	____________________________

Do you receive income from or have any interest in any trust?____________________

If yes, please describe and provide a copy of the trust instruments. _______________

____

____

____

ASSETS (if any asset is jointly held, please give name of joint owner).

Real Estate

Does applicant own any real estate? Yes_____________No___________________

Description of Property	Approximate Value	Name(s) on Deed

Are there any liens or mortgages against the property? Yes_______No________

If yes, in the amount of $_______________Payable to__________________________

Was this real estate your home prior to entering the nursing home? Yes_____No_____

Is your spouse now living in the home? Yes______No______

Do you have a "life use" of any real estate (any ownership interest, in full or in part for your lifetime, or the right to occupy property for your lifetime? Yes______No_______

If yes, please describe.____

____

____

____

CASH ASSETS

Please list all assets including but not limited to: Savings Accounts, Checking Accounts, Money Market, Stocks, Bonds, C.D.'s

Name of Institution	Account #	Present Balance
______________________	______________________	____________________
______________________	______________________	____________________
______________________	______________________	____________________
______________________	______________________	____________________
______________________	______________________	____________________

TRANSFER OF ASSETS

Within sixty (60) months prior to the date of this application, have you given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind (cash, securities, real estate, etc.) or closed any accounts (including adding or removing someone's name from the account)? If so, please describe fully all such gifts or transfers in excess of $1,000, including the asset transferred, names, addresses and relationship to you of the person to whom the gift or transfer was made, and the value of the gift or transfer.

Gifts or transfers within 60 months: Yes__________No__________

Please describe:____

____

____

____

Within sixty (60) months prior to the date of this application, have you created any trusts or placed funds or any other assets in a trust that already existed

Yes______No_____If yes, please describe and provide a copy of the trust instrument.

____

I hereby certify that this a true and complete statement of the applicant's current income and assets and any gifts or transfers in excess of $1,000 and any trusts created or transfers of assets to any trust that they may have made within the sixty (60) months prior to the date off this application.

____

(Applicant)

____

(Responsible Party)

____

(Date)

TO: APPLICANTS FOR ADMISSION AND THEIR FAMILIES

BayView Healthcare Has a provider agreement with the State of Florida to provide services to Medicaid recipients pursuant to Title XIX of the Social Security Act, and to provide services to Medicare recipients pursuant to Title XVII of the Social Security Act.

State and federal law and regulations impose the following limitations on the advance payment and deposit requirements of nursing homes:

- No nursing home may request an advance payment or deposit from a Medicare beneficiary for any services or supplies covered by Medicare as a condition of admission.
- A nursing home may request an advance payment or deposit of up to one thousand five hundred dollars ($1,500.00) from an applicant who has applied for Medicaid, provided such payment or deposit is held in an account for the applicant's benefit and returned to the applicant when he is determined eligible for Medicaid.
- No nursing home may request an advance payment or deposit from a Medicaid recipient as a condition of admission.
- Upon admission, **BayView Healthcare** requires self-pay residents or their responsible party, to pay the facility an advanced room and board payment equal to forty five (45) days at the current self pay per diem rate.

In compliance with State and Federal laws, **BayView Healthcare** admits and treats all residents equally, regardless of race, color, sex, national origin, or source of payment.

(PLEASE RETURN WITH APPLICATION)

I acknowledge that I have received a copy of this statement. The facility has explained the information in the statement to me and I am signing this statement to show my understanding.

______________________________	______________________________
Name of Resident	**Signature of Resident**
	-OR-
______________________________	______________________________
Name of Representative	**Signature of Representative Party***

____
Date

*If a representative party is signing this form on behalf of the resident, indicate below his or her relationship to the resident.

____
Relationship

THIS NOTICE MUST BE SIGNED AND RETURNED TO US BEFORE
WE CAN ADMIT ANY RESIDENT.

(PLEASE RETURN WITH APPLICATION)