BayView Healthcare

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 ___________________________

VA Benefits $ ___________________________ /Mo ___________________________

Annuities $ ___________________________ /Mo ___________________________

Interest $ ___________________________ /Mo ___________________________

Dividends $ ___________________________ /Mo ___________________________

Other $ ___________________________ /Mo ___________________________

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

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<thead>
<tr>
<th>Name of Institution</th>
<th>Account #</th>
<th>Present Balance</th>
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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.
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)