On behalf of Bethesda, we would like to thank you for your interest in completing the Application for Admission for our Skilled Nursing Community. As a not-for-profit health care organization, we have proudly served the St. Louis community for 130 years by fostering successful aging through compassion and innovation.

Listed below are the admission forms and process. Please print and complete forms 1 and 2 and email, fax or make delivery arrangements of forms to the community Admission Counselor listed below. Once received we will review and respond to the designated contact listed.

INSTRUCTIONS:

1. **Application for Admission** (2 pages)
    - Please complete requested information as completely as possible. Sign and date application.
2. **Assignment of Benefits**
    - The assignment of benefits allows us to treat and provide medical care and bill for services that are covered by your insurance.
3. **Medical Information**
    - If hospitalized or in another nursing community you will authorize your social worker or case manager to send medical information to our community for our approval and acceptance verification.
    - If coming from home you will need to have the physician's office fax a current (within last 30 days) history and physical along with current list of medications to our community for approval and acceptance verification.

Additional required items needed prior or during move-in timeframe:

- Social Security, Medicare or current insurance card copies
- Financial Power of Attorney (POA), Durable Power of Attorney (DPOA) and Living Will
- The Room and Board deposit check for remainder of month and following month
- Additional paperwork will be completed at time of or prior to actual move—in person or via Docusign.

The Admission Counselor is here to guide and support with you each step of the admission process. Their goal is to make your loved ones transition into the Bethesda family seamless and as easy as possible.

ADMISSION COUNSELOR CONTACT INFORMATION

Community	Phone	Secured Fax
Bethesda Dilworth 9645 Big Bend Blvd Oakland, MO 63122	314-446-2147	314-446-2117
Bethesda Meadow 322 Old State Rd Ellisville, MO 63021	636-449-1651	636-394-5037
Bethesda Southgate 5943 Telegraph Rd. Oakville, MO 63129	314-375-1001	314-846-4661
Bethesda & Barnes-Jewish Extended Care 401 Corporate Park Dr. Clayton, MO 63105	314-797-5758	314-725-4189

BETHESDA LONG TERM CARE INC.
APPLICATION FOR ADMISSION

Please check one: ❑ LTC/Skilled Nursing ❑ Memory Support ❑ Respite Care ❑ Hospice Care

Date of Application:_____ Anticipated Admission Date:_____

Full Name:_____ Preferred Name:_____

Address:_____ Social Security #:_____

City/State/Zip:_____ Medicare #:_____

Phone:_____ Medicaid #:_____

Present Location:_____ Birthdate:_____Age:_____

Referred By:_____ Marital Status: (circle) M W D S

Responsible Party:_____ Relationship:_____

RP Address:_____ City/State/Zip:_____

Email:_____ Cell Phone:_____

Home Phone:_____ Work Phone:_____

Current Pharmacy:_____ Transition to Omnicare Pharmacy: ❑Yes ❑No

To be notified in case of emergency: (Name, Address, Zip, Phone Numbers, Relationship, Email)

1._____

2._____

3._____

HEALTH INSURANCE & PHYSICIANS (COPIES OF ALL CARDS WILL BE MADE)

Primary Insurance:_____ ID#:_____

Secondary Insurance:_____ ID#:_____

Current Physician:_____Phone:_____

FUNERAL INFORMATION

Name of Funeral Home:_____ Has the funeral home been prepaid? ❑Yes ❑No

FINANCIAL INFORMATION & RESOURCES

Social Security Income per month $_____ VA Pension $_____ Private Pension $_____

Dividends $_____ Interest $_____ Other $_____

Long Term Care Insurance Provider:_____ Daily/Monthly Benefit:_____

Market Value of Stocks/Bonds/Retirement Accounts:_____

Name of Bank_____ Balance $_____ ❑Checking ❑Savings

Name of Bank_____ Balance $_____ ❑Checking ❑Savings

Name of Bank_____ Balance $_____ ❑Checking ❑Savings

Have you sold or given away any money, vehicles, property or any resource within the last 5 years?

❑Yes ❑No If yes: What:_____Value:_____ To Whom:_____

POWERS OF ATTORNEY – HEALTHCARE & FINANCES

Who manages your financial affairs?_____relationship:_____

Do you have a health care Power of Attorney? ❑No ❑Yes Designee:_____

Do you have a financial Power or Attorney? ❑No ❑Yes Designee:_____

Do you have a Legal Guardianship? ❑No ❑Yes Designee:_____

Do you have a Living Will? ❑No ❑Yes Please Submit Copies of All Documents

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The undersigned agrees to pay in ADVANCE the monthly charges rendered for room, meals and nursing services.

I hereby voluntarily apply for admission to _____. If I am admitted to this facility, I agree to comply with its rules and regulations, responsibilities and by-laws that may from time to time be established by it. I also expect the same consideration of rights stipulated in the Resident's Bill of Rights and Responsibilities. I understand that, if admitted, I am to remain in _____ only as long as my stay is agreeable both to Bethesda Health Group and to me.

I (we) hereby waive, relinquish, and abandon any and all claims, demands, suits or actions which I (we) may in the future have against Bethesda, its directors, agents, servants and employees, or any of them based upon any act or omission, occurring in connection with or arising as a result of the investigation of my (our) credit history and standing and financial responsibility herein authorized.

I do warrant that all foregoing statements, representations and declarations made by me are true; that I have fully and fairly answered each question therein contained and that I have not concealed or misrepresented any material fact.

_____ _____

Signature of Resident/Resident's Representative Date

Should the applicant, at some future date, be unable to meet the cost of the Bethesda Services, I (we), the undersigned, will assure the facility is notified 90 days in advance and that the undersigned will assure that the resident's assets are utilized for facility payment and that the undersigned will apply for Medicaid on behalf of the resident when the resident's funds become depleted.

_____ _____

Signature of Resident/Resident's Representative Date

_____ _____

Administrative Approval Date

❑BJ Extended Care
❑Dilworth
❑Southgate
❑Eunice Smith
❑Meadow
❑Christian Extended Care & Rehabilitation

ASSIGNMENT OF BENEFITS

Resident's Name:_____Medical Record Number_____

I, the above named, request payment of authorized Medicare, Medicaid and/or other insurance benefits be made to Bethesda Long Term Care for any service furnished me. I authorize any holder of medical and other information about me to release to Medicare, Medicaid and/or other insurance and their agents such information needed to determine these benefits related services.

Authorization to Treat

I consent to/and authorize the administration and performance of medical care by Bethesda Long Term Care according to a physician's plan of care.

I acknowledge that my health information may be transmitted electronically to the appropriate regulatory agency(ies) by way of the minimum data set.

_____ _____

Resident or Resident's Representative Date

- ❑ BJ Extended Care
- ❑ Eunice Smith
- ❑ Southgate
- ❑ Dilworth
- ❑ Meadow
- ❑ Christian Extended Care & Rehabilitation