Fairport Baptist Homes caring.vibrant.vital

APPLICATION COMPLETION INSTRUCTIONS

Confidential

Fairport Baptist Homes
4646 Nine Mile Point Road, Fairport NY 14450
Admissions Phone: (585) 388-2307
Admissions Fax (585) 388-2388

It is appreciated if you would be as complete as possible when answering these questions. Answering all questions allows our Admissions Office to process your application as quickly as possible and to help serve you efficiently.

ADMISSIONS APPLICATION

Please enclose copies of any of the following which pertain to you. Failure to provide copies may result in a delay in processing your application.

Social Security Card
Medicare Card
Medicaid Card
Major Medical Insurance Card
Medicare D Prescription Plan
Body Organ Donor Card
Long-term Care Insurance Card
Power of Attorney Form
Living Will/Health Care Proxy

Everyone is encouraged to call your insurance carrier directly to obtain details regarding your specific insurance coverage and benefit package. It is important to note that if you have benefits, you still must meet criteria /qualifications set forth by your insurance carrier. You should be aware, in advance, of placement of any potential deductibles and/or co-payment requirements. All long-term residents of Fairport Baptist Homes are required to appoint a Power of Attorney and have a Health Care Proxy.

Please be sure to give us the name and complete address of your current Physician (and other Specialists) so medical information may be obtained prior to admission (see question 12.) Your signature on this form is necessary in order to obtain medical information from a Physician's office, hospital, and/or clinic. Copies of this form may be included with letters requesting information on your medical condition.

Applicants for Rehabilitation: Please attach a complete listing of your current medications

Prescheduled Surgery Date:____

Procedure:____

Hospital:____

APPLICATION FOR ADMISSION - Fairport Baptist Homes

ADM-22

Full Name (please print)	Date Mailed	Date Received

Application submission for (circle): Rehabilitation or Long-Term: ACTIVE INACTIVE

1. Present Address ____________________

   ____________________ County ____________________

   How long at this address? __________ Phone # __________ Cell # __________

2. Circle: Married Widow Widower Single Divorced

   Spouse's Name ____________________

3. Contact Persons (Nearest Relatives or Significant Others). List in order of contact. Attach another sheet if necessary. Please circle if individual is your Power of Attorney (POA) or Health Care Proxy (HCP)

   a. Name ____________________ Relationship __________ POA HCP

   Address ____________________

   ____________________ Home Phone ____________________

   Business Phone ____________________ Other (cell/pager) ____________________

   b. Name ____________________ Relationship __________ POA HCP

   Address ____________________

   ____________________ Home Phone ____________________

   Business Phone ____________________ Other (cell/pager) ____________________

   c. Name ____________________ Relationship __________ POA HCP

   Address ____________________

   ____________________ Home Phone ____________________

   Business Phone ____________________ Other (cell/pager) ____________________

4. Social Security # ____________________ Medicare # ____________________

   Medicaid # (if applicable) __________ CIN # __________ County __________

5. How long do you expect to be self-pay? ____________________

   (We do require some basic financial information for all active long-term applicants)

6. Health Insurance Coverage ____________________ Contract # ____________________

   List any other Insurance (e.g.: MVA, Workers' Compensation) ____________________

   Contract / Claim # ____________________

   Name and Address of Representative: ____________________

   Do you have a Long-term Care Insurance Policy? YES NO

   Company ____________________ Contract # ____________________

   Medicare D Prescription Plan Coverage Company ____________________

7. Church Membership ____________________ Denomination ____________________

8. Birth date __________ Birthplace __________ Citizenship __________

Maiden Name of Mother_________________________________Birthplace________________

Father's Full Name_____________________________________Birthplace_________________

9. Your Occupation ____

Employed with or Retired from ____

Last Employment/Retirement Date____

10. Funeral Home/Burial Instructions: Name____

Address ____Phone #______________

Cemetery____

11. Are you an Organ Donor? YES NO

Long-term residents are encouraged to use the Home's Medical Director as your personal Physician for expedience, safety and convenience in the handling of emergencies as well as regular necessities. If you wish to retain your own Physician, please ask for more information regarding NYS Department of Health regulations and check with your Physician to confirm that he/she will follow you once admitted to a Residential Health Care Facility. Rehabilitation patients are followed by our attending Physician during your stay. Communication is made with your Primary Care Physician as needed and a Discharge Summary is sent following discharge.

12. Primary Care Physician's Full Name____

Address____

____

Phone #____Fax #______________________

List other Physicians/Specialists whom you have been seeing (e.g., Surgeon, Dentist, Optometrist, Dermatologist and Psychiatrist)

a. Name____

Address____

______________________________Phone #_________________Specialty____________________

b. Name____

Address____

______________________________Phone #_________________Specialty____________________

13. Have you been under a Physician's care during the past year? YES NO

General Diagnosis____

____

Physical Disabilities ____

Past Surgeries____

Please list any hospital and/or nursing home stays within the past year.

____

____

14. Allergies____

15. Special Diet____

16. Do you smoke currently?____________________ ***The Fairport Baptist Homes is a smoke-free facility***

APPLICATION AGREEMENT/RELEASE OF INFORMATION CONSENT FORM

I, ________________________________, an applicant for admission to the Fairport Baptist Homes, do hereby agree that any false answer to statements herein submitted shall be cause for rejection of this application.

The Fairport Baptist Homes of Fairport, New York, or its accredited representatives, has my permission to obtain full and detailed information from any doctor, hospital or clinic to whom I am or have been known regarding any consultations I have had with them, including the reason, the diagnosis and the nature and result of the treatment. I also authorize any holder of medical or other information about me to release to the Social Security Administration, or its intermediaries or carriers, any information needed for any Medicare or insurance claim. I request that payment of authorized benefits be made on my behalf.

I hereby certify that the answers to the foregoing questions and papers are full and complete and that I have truthfully answered all questions.

Signed____Date_____________________

(May be signed by Applicant or Legal Representative)

Relationship to Applicant____

Some Physicians utilize their own consent form and might not accept the above. It is recommended that you speak directly with your Personal Physician, inform him/her that you are submitting this application and sign any necessary consent forms specific to your Physician's office, hospital and/or clinic. This will help avoid any possible delays in processing this paperwork and obtaining necessary information which will allow our staff to learn about the care needs of you or your loved one.

Admissions to Fairport Baptist Homes are made regardless of age,
race, creed, color, national origin, sex, disability, sexual
orientation, marital status or source of payment.

SAVE FORM