



Albany Memorial Hospital Samaritan Hospital Northeast Health

PRE - ADMISSION UNIVERSAL APPLICATION

Present Location: Albany Memorial _____

Samaritan Hospital _____

I. GENERAL INFORMATION

Date: _____

PATIENT INFORMATION:

Last: _____ First: _____ Initial: _____

Address: _____

City: _____ State/Zip: _____

II. INSURANCE INFORMATION

Medicare: _____

Other Insurance: _____

Medicaid Application Pending: Yes No If Yes, Date Submitted: _____ County: _____

Name and Relationship of Individual Representing Patient: _____

Address: _____

City: _____ State/Zip: _____

Telephone: _____ Work/Cell Phone: _____

Status: (Please Check) Power of Attorney Legal Guardian Health Care Proxy

Person Responsible for Handling Financial Transactions

Patient's Marital Status: Single Married Widowed Separated Divorced

U.S. Citizen: Yes No

Primary Physician:

Name: _____ Phone: _____

III. FINANCIAL DISCLOSURE (All information is kept confidential)

INCOME	MONTHLY AMOUNT
Social Security	\$ _____
Retirement Pension	\$ _____
Veteran's Pension	\$ _____
Railroad Pension	\$ _____
Supplementary Security Income	\$ _____
Annuities	\$ _____
Other Income	\$ _____
Total Monthly Income	\$ _____

ASSETS

CHECKING ACCOUNTS:

Bank Name: _____

Account Balance \$ _____ Joint Account: Yes No

SAVINGS ACCOUNTS:

Bank Name: _____

Account Balance \$ _____ Joint Account: Yes No

OTHER ACCOUNTS:

Bank Name: _____

Account Balance \$ _____ Joint Account: Yes No

CERTIFICATES OF DEPOSIT:

Bank Institution: _____ Balance: \$ _____

Does the patient own a home: Yes No Estimated Value: \$ _____

If yes, is the home jointly owned with anyone? _____

Does the patient have Long Term Care Insurance: Yes No

If yes, with Insurance Company _____

Other Assests (e.g. stocks, bonds, other) (Please list)	Amount
1. _____	\$ _____
2. _____	\$ _____
3. _____	\$ _____

Have any assets been transferred in the last 60 months: Yes No

If yes, please describe: _____

Has an estate trust been established: Yes No Date established: _____ If yes, please provide copy

To the best of my knowledge, all the information provided is correct and valid. I understand that the information contained in this form will be shared with nursing homes.

X _____
Signature of Patient or Responsible Party Date

The information provided shall remain confidential and shall be made available only to authorized hospital and nursing home personnel involved in the placement process and to any governmental officials authorized access by law to such records. The facilities having access to the information do so without regard to race, creed, color, age, sex, religion, national origin, sponsor, sexual preference, disability or marital status. Persons under 18 years of age are not eligible for admission consideration unless special approval has been received from the Department of Health.