

## Elant Pre-Admission Form

1. Complete all required information on the following form
2. Save it to your computer
3. Email this form as an attachment to [info@elant.org](mailto:info@elant.org)





LONG TERM CARE  
PRE-ADMISSION INFORMATION

GENERAL INFORMATION

DATE: \_\_\_\_\_

Patient Information:

Name: \_\_\_\_\_  
Last First MI

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Marital Status:  Single  Married  Widowed  Separated  Divorced

Patient's Present Location (if different than above):

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Person(s) Representing Patient:

Name: \_\_\_\_\_  
Last First MI

Relationship to Patient: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Status:  Power of Attorney  Guardian  Handling Financial Transactions  Other \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI

Relationship to Patient: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Status:  Power of Attorney  Guardian  Handling Financial Transactions  Other \_\_\_\_\_

Medical Insurance (other than Medicare): \_\_\_\_\_

Medicaid Application  
(check one):

Approved

If approved, Medicaid # \_\_\_\_\_

Pending

If pending, date submitted \_\_\_\_\_

Not Applicable

County: \_\_\_\_\_

DSS Worker's Name: \_\_\_\_\_



**Patient's Primary Physician:**

Name: \_\_\_\_\_

Telephone (\_\_\_\_) \_\_\_\_\_

**Income:**

**Monthly Amount**

Social Security	\$ _____
Retirement Pension	\$ _____
Veteran's Pension	\$ _____
Railroad Pension	\$ _____
Supplementary Security Income	\$ _____
Annuities	\$ _____
Other Income	\$ _____
<b>Total Monthly Income</b>	<b>\$ _____</b>

**Assets:**

**Checking Account**

Bank: \_\_\_\_\_

Balance: \$ \_\_\_\_\_ Joint Account?  Yes  No

**Savings Account(s)**

Bank: \_\_\_\_\_

Balance: \$ \_\_\_\_\_ Joint Account?  Yes  No

Bank: \_\_\_\_\_

Balance: \$ \_\_\_\_\_ Joint Account?  Yes  No

**Certificates of Deposit**

Bank/Financial Institution: \_\_\_\_\_

Does the patient own a home?  Yes  No If yes, estimated value: \$ \_\_\_\_\_

Is the home jointly owned?  Yes  No

**Other Assets (please list):**

**Amount**

1.	_____	\$ _____
2.	_____	\$ _____
3.	_____	\$ _____

Have any assets been transferred from the patient to others in the last 36 months?  Yes  No

If yes, please describe: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has an estate trust been established?  Yes  No If yes, please provide a copy.

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

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient or Responsible Party



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