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

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	$____________
Other Income	**$**____________
Total Monthly Income	$____________

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

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 THIS 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.