(907) 235-0233

South Peninsula Hospital
Long Term Care
4300 Bartlett Street
Homer, AK 99603

LONG TERM CARE

CONFIDENTIAL APPLICATION FOR REVIEW & CONSIDERATION OF ADMISSION

Notice to Applicant(s): Completion of this application is not a guarantee of Admission. Admission is a several step process. Cooperation with the SPH Finance Team is required to determine payment for services. If an applicant is not admitted, confidential personal and financial records can be returned to the individual and/or her/his family member assisting with this application if desired.

Information obtained in this Admission Application will be used to assist and serve residents and their families to the best of our abilities. This information is confidential and will only be used by LTC facility leadership. SPH LTC privacy practices can be provided upon request.

SPH LTC is a Medicare and Medicaid certified facility and is a not-for-profit facility that provides the highest quality care to our residents. It is the policy and practice of SPH LTC to admit and treat all persons without regard to age, race, gender, color, religious expression, national origin or disability.

This application is not considered to be completed until it is appropriately signed and all fields are complete to the best of applicant's ability.

Please Note: SPH LTC is a tobacco-free facility and campus. Use of tobacco and/or other drugs, including marijuana in any form are prohibited. Individuals who currently use tobacco products may be denied admission.

I. PERSONAL INFORMATION

Legal Name (Last, first & middle initial):		Birth [last] name:
Preferred Name (how you wish to be addressed):		Home Phone #: Cell Phone #:
Physical Address/Street:		
City:	State:	Zip:
Mailing Address:		
Place of Birth:		Date of Birth:
Age:	Marital Status:	Gender:
Social Security Number (SSN):		

Faith Tradition:	
Race: Caucasian/White _____ American Indian _____ Alaska Native _____ Asian _____ Black or of African Descent _____ Hispanic/Latino _____ Native Hawaiian or Other Pacific Islander _____ Other: ________________________	
Last Known/Recorded Height: _______ Last Known/Recorded Weight: _______	
Primary Language Spoken:	Preferred Language Spoken:
Allergies:	
Education: 8th Grade or Less _____ High School Education _____ Bachelor Degree _____ Graduate Degree _____ Technical or Trade School _____	
Funeral Arrangements (Answer Mortician if already Arranged):	
Community Pharmacy:	
Use of Tobacco Products: ____Yes _____No Recently Quit: _____Yes Date:______________ _____N/A	

II. ADVANCE DIRECTIVES/LEGAL DOCUMENTS

Check all that apply with an "X". Please provide a copy of these document(s) to this application.

- Durable Power of Attorney for Health Care _____
- General Power of Attorney for Finance _____
- Conservator _____
- Familial Guardian _____
- State Guardian or Conservator _____
- Living Will _____
- Advance Directives for Health Care ____
  (e.g.; "5 Wishes" or other form for Care Requests) (please state name of the advance directive form)
- Alaska MOST (Medical Orders for Scope of Treatment) _____
- Other; please give the form's title: ____

III.

EMERGENCY CONTACTS

Contact #1

Name:		Relationship:
□ Phone: □ Home: □ Cell:	□ Email: Select one preferred method of contact	
Contact Type: Durable Power of Attorney for Health Care _____ Power of Attorney Financial _____ Guardian _____ Conservator _____ Next of Kin _____ Family _____ Friend _____ Relationship of NOK and/or family and/or friends		
Mailing Address		
City	State	Zip

Contact #2

Name:		Relationship:
□ Phone: □ Home: □ Cell:	□ Email: Select one preferred method of contact	
Contact Type: Power of Attorney for Health Care _____ Power of Attorney for Financial _____ Guardian _____ Conservator _____ Next of Kin _____ Family _____ Friend _____ Relationship of NOK and/or family and/or friends		
Mailing Address		
City	State	Zip

Contact #3

Name:		Relationship:	
Phone: Home: Cell:	Email:		
Contact Type: Power of Attorney for Health Care _____ Power of Attorney for Financial _____ Guardian _____ Conservator _____ Next of Kin _____ Family _____ Friend _____ Relationship of NOK and/or family and/or friends			
Mailing Address			
City		State	Zip

Additional Contacts may follow on last (addendum) page

IV. BILLING / INSURANCE INFORMATION

Medicare – Please attach a copy of card

Medicare Coverage (circle all that apply): Part A _____ Part B _____ Part D _____
Medicare (HIC)#:
Medicare Beneficiary ID:
Part D Policy #

Medicaid – Please attach a copy of card

Medicaid Case #:
If no Medicaid coverage, have you applied? ○ Yes ○ No
Community Care Coordinator's Name:

Other Insurance – Please attach a copy of card

Insurance Name:
Insurance Policy #:

Veteran's Administration – Please attach a copy of card

VA #:

Drivers' License and/or State Identification Card – Please attach a copy of card

Driver's License _____ & Number ____________

State ID Card _____ & Number ______________

I have carefully read this application and I have answered all questions correctly to the best of my knowledge and belief.

Signed: ______________________________________ Date: __________________
Applicant or Legal Power of Attorney

Printed Name: _________________________________

Relationship to Applicant if not signed by the Applicant: ____________________

ADDENDUM

Contact #4

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<tr><td>Phone:

Home:

Cell:</td><td colspan="3">Email:</td></tr>
<tr><td colspan="4">Contact Type:

Power of Attorney for Health Care _____ Power of Attorney for Financial _____

Guardian _____ Conservator _____ Next of Kin _____ Family _____ Friend _____

Relationship of NOK and/or family and/or friends</td></tr>
<tr><td colspan="4">Mailing Address</td></tr>
<tr><td colspan="2">City</td><td>State</td><td>Zip</td></tr>
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Contact #5

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Home:

Cell:</td><td colspan="3">Email:</td></tr>
<tr><td colspan="4">Contact Type:

Power of Attorney for Health Care _____ Power of Attorney for Financial _____

Guardian _____ Conservator _____ Next of Kin _____ Family _____ Friend _____

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