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

(907) 235-0233

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, religiousus 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 and/or marijuana products may be denied admission.

1. 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:

Use of Tobacco Products: ☐ Yes ☐ No

Recently Quit: ☐ Yes Date: ☐ N/A

Use of illicit drugs: ☐ Yes ☐ No

2. ADVANCE DIRECTIVES/LEGAL DOCUMENTS

Check all that apply. Please provide a copy of these document(s) with 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") (please state name of the advance directive form)
- ☐ Alaska MOST (Medical Orders for Scope of Treatment)
- ☐ Other; please give the form's title:

3. 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:		Email:	
Home:			
Cell:			
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

4. BILLING / INSURANCE INFORMATION

Medicare – Please attach a copy of card

Medicare Coverage (check 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 #:	
When is the applicant's next Medicaid renewal date?	
If no Medicaid coverage, has the applicant 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 #:

What is the applicant's VA service-connected disability percentage? _____

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

Driver's License _____ & Number _____

State ID Card _____ & Number _____

Other documents the SPH finance team may request to verify financial eligibility – *For your information only.* We will contact you directly if additional documentation is needed. We recommend beginning to gather these documents in advance to help prevent any delays in the admission process.

- 12 months bank statements (checking, savings, and retirement)
- Close out statement from any account that has been recently closed
- Income statements from SSI and dividends
- If the applicant owns a home or other real property, we will need documentation of the **fair market value, current equity,** and any **outstanding mortgage** or **liens.** Please also provide information regarding any additional property you own.

5. Clinical Information

Please have your primary care provider, case worker, discharge planner, or other healthcare professional submit clinical documentation to ltcadmits@sphosp.org, including:

- Recent History and Physical (H&P)
- Diagnoses
- Current medication list
- Relevant progress notes
- Other supporting medical records stating why LTC placement is necessary

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:** _____