

Admission Application Record

Name: _____ **S.S.N.:** _____
Street Address: _____ **Phone:** _____
City: _____ **State:** _____ **Zip:** _____
Preferred Name: _____

Birth Date: _____ **Age:** _____ **Race:** _____ **Sex:** _____ **Marital Status:** _____

Medicare # : _____ Part A: Yes No
Medicaid #: _____ Part B: Yes No
Health Insurance: _____
Primary Physician: _____ **Phone:** _____

Emergency Contact: Name _____ Relationship: _____
Address _____
Phone: Home _____
Work _____
Cell _____

<u>Current Assets:</u>	<u>Current Liabilities:</u>
Bank Accounts _____	Accounts Payable _____
Other Assets _____	To Others _____
Total _____	Other Debts _____
	Total _____

There are funds to pay for care at FNC for: (less than six mo. , (_____ mo.)
(At least 1 yr.) (2 yrs.) (More than 2 yrs.)

<u>Property:</u>	<u>Monthly Income:</u>
Does this patient own a home? _____	Social Security \$ _____
Approximate Value? _____	Retirement/Pension \$ _____
	Other Income \$ _____

I certify that information contained in this application is accurate to the best of my knowledge. I understand that if any information has been falsely represented, this will be sufficient cause for voiding my application for admissions, and for my removal from Fairfax Nursing Center.

Signature of Patient/Responsible Party Date

Signature of Fairfax Nursing Center Representative Date