PROVIDENCE
Extended Care
920 Compassion Circle
Anchorage, Alaska 99504 ☐

Application for Admission

(SMOKE FREE CAMPUSES)

PROVIDENCE
Transitional Care
Center
☐ 910 Compassion Circle
Anchorage, Alaska 99504

Demographic Information

Applicant Name: _____ Spouse: _____

Home Address: _____ DOB: _____

Home Phone# _____ Cell # _____ Work# _____

Social Security # _____ Circle One: ***Married*** ***Never Married*** ***Divorced*** ***Widowed***

Do you have any of the following? Power of Attorney ☐ Legal Guardian ☐ Health Care Directive ☐

******If above is check marked, please provide copy******

Spouse or Emergency Contact

Name: _____

Address: _____

Phone(s): _____ Relationship: _____

Primary Insurance: _____ Secondary Insurance: _____

****** If primary insured is under 65 yrs old and still working or has a working spouse, private insurance will be primary.***

Insurance (*Please attach a copy of all insurance cards*):

Medicare # _____

Prescription Plan _____

Member Rx ID# _____

Check One:

☐ Part A and B

☐ Part A Only

☐ Part B Only

Have you been Hospitalized or in a SNF in the last 60 days?

If yes, please list when and where. _____

Note: Please see the attachment which lists Medicare Part D plans that we contract with; if your plan is not listed, you will have to pay out of pocket costs for pharmaceuticals and seek reimbursement from your insurance company.

Medicaid# _____

If no have you applied in the last 30 days? _____ **If YES, when?** _____

****** Please attach a copy of Medicaid application if pending******

Note: Medicaid covered Applicants may be required to pay a Cost of Care, as determined by the Division of Public Assistance. For additional questions, you may contact our Financial Counselor at 907-212-2160.

Private Insurance Name: _____

Policy Holder's Name and DOB: _____

Policy Number: _____ Group# _____

Insurance Address: _____ Phone# _____

Veteran's Administration# _____

Our facilities rates are posted on schedule of charges handout.

I have carefully read this application and all attachments, I have answered all questions correctly to the best of my knowledge and belief. I acknowledge that I will be responsible for payment of all charges unless otherwise indicated.

_____ _____

Applicant Signature **Date**

_____ _____

POA/ Legal Guardian/ Rep Payee Signature **Date**

****This application is not considered complete until it is appropriately signed and all blanks are filled in. Thank you, Admissions Dept**