

LASATA CARE CENTER

W76 N677 WAUWATOSA RD

CEDARBURG, WI 53012

PHONE# 262-512-2833 PRIMARY FAX#

262-512-2842 Alternate FAX# 262-377-4202

APPLICANT INFORMATION FOR SHORT-STAY ADMISSION

Name: _____ Maiden name: _____ SS#: _____

Date of birth: _____ Place of Birth: _____ Phone: _____

Current address: _____ Marital Status: _____

City: _____ State: _____ ZIP Code: _____

Physician: _____ Physician Phone: _____ Year moved to Ozaukee County: _____

Funeral Home: _____ Phone Number: _____

INSURANCE INFORMATION

Medicare Number: _____ Medicare HMO Name: _____

Medicare HMO Subscriber Number: _____ Medicare HMO Phone Number: _____

Secondary Insurance: _____ Policy Number: _____

Medicaid/T19 Number: _____

Medicare D/Prescription Drug Coverage Insurance Name: _____ POA-HC/ Living Will: Yes No POA Finances: Yes No

PREVIOUS NURSING HOME STAYS

Have you ever been a resident at another nursing home or rehabilitation facility?
 Yes _____ No _____ If yes, where? _____ Dates of Stay? _____

EMERGENCY CONTACT 1

Name: _____ Relationship: _____

Address: _____ Phone: _____ alt. phone: _____

City: _____ State: _____ ZIP Code: _____

EMERGENCY CONTACT 2

Name: _____ Relationship: _____

Address: _____ Phone: _____ alt. phone: _____

City: _____ State: _____ Zip Code: _____

RESPONSIBLE PARTY INFORMATION (Send Bill To)

Name: _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ ZIP Code: _____

Although you may have Medicare and insurance benefits, there is no guarantee of payment. While we will be responsible for billing your primary insurance and although we may assist you in billing your secondary insurance, your agreement with your insurance company is between you and them. Lasata will expect payment in full of all coinsurance and non-covered services upon your receipt of the billing statement. To continue the pre-admission assessment and evaluation, please complete the information below. Please check (✓) the most accurate range below.

ASSETS: (not including home)		Monthly Income	
<input type="checkbox"/>	Less than \$10,000	<input type="checkbox"/>	Less than \$1000
<input type="checkbox"/>	\$10,000-\$25,000	<input type="checkbox"/>	\$1000-\$3000
<input type="checkbox"/>	\$25,000-\$50,000	<input type="checkbox"/>	\$3000-\$5000
<input type="checkbox"/>	\$50,000-\$100,000	<input type="checkbox"/>	\$5001 +
<input type="checkbox"/>	\$100,000-\$200,000	<input type="checkbox"/>	
<input type="checkbox"/>	\$200,00 +	<input type="checkbox"/>	

I certify that the information contained within this application is a true and complete statement of facts.

Signature of applicant: _____ Date: _____

***Please fax application Attention Admissions 262-512-2842 or email to: kandrasic@co.ozaukee.wi.us**