



Specialized Care by Dedicated Professionals

Admission Application Record

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

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

Medicare # : _____ Part A: Yes No

Medicaid #: _____

Health Insurance: _____

Primary Physician: _____ **Phone:** _____

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

Current Assets:

Current Liabilities:

Bank Accounts _____ Accounts Payable _____

Other Assets _____ To Others _____

Other Assets _____ Other Debts _____

Other Assets _____ Other Debts _____

Total _____ 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.)

Property:

Does this patient own a home? _____

Approximate Value? _____

Monthly Income:

Social Security \$ _____

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

Please fax to Fairfax Nursing Center after you have completed this form.
Fax numbers are 703-273-7329 or 703-273-2365.

