APPLICATION FOR: THOBURN VILLAGE
CRIBBS RESIDENTIAL CENTER

31 North Park Avenue, Meadville, PA 16335

Please complete form (one per person) and return to the Marketing Department

INDIVIDUAL INFORMATION

Full Name of Applicant ______________________

Mailing Address ______________________

City ____________ State ____________ Zip ____________

Home Phone ____________ Cell Phone ____________

Email Address ______________________

Gender ☐ Male ☐ Female Nickname ____________

SSN ____________ Date of Birth ____________ Birthplace ____________ Age ______

Status: ☐ Single ☐ Married – Spouse's Name ____________ Date ______ ☐ Widowed ☐ Divorced

Are you a Veteran? ☐ Yes ☐ No Veteran's Spouse? ☐ Yes ☐ No VA Claim No. ____________

Religious Facility ____________ Denomination ____________

Address ____________ Clergy ____________

Former Occupation(s) ______________________

Automobile make ____________ Color ______ Year ______ Plate Number ____________

CONTACT INFORMATION

Power of Attorney (POA) ☐ Yes ☐ No

Name of POA ____________ Home Phone ____________

Address ____________ Cell Phone ____________

City / State / Zip ____________ Work Phone ____________

Relationship of POA: ☐ Spouse ☐ Child ☐ Other ____________

Email ______________________

Name of Responsible Party ____________ Home Phone ____________

Address ____________ Cell Phone ____________

City / State / Zip ____________ Work Phone ____________

Email ______________________

Person Paying Bills ____________ Home Phone ____________

Address ____________ Cell Phone ____________

City / State / Zip ____________ Work Phone ____________

Email ______________________

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EMERGENCY CONTACTS

Names and addresses of nearest relatives who may be contacted regarding their health status in the order listed below:

Name ______________________ Home Phone ______________________

Address ______________________ Cell Phone ______________________

City / State / Zip ______________________ Work Phone ______________________

Relationship ______________________ Email ______________________

Name ______________________ Home Phone ______________________

Address ______________________ Cell Phone ______________________

City / State / Zip ______________________ Work Phone ______________________

Relationship ______________________ Email ______________________

Name ______________________ Home Phone ______________________

Address ______________________ Cell Phone ______________________

City / State / Zip ______________________ Work Phone ______________________

Relationship ______________________ Email ______________________

HEALTHCARE INFORMATION

Do you have Advanced Directives? *(Please circle all that apply, if Yes please attach)*

Do Not Resuscitate Living Will Will Durable POA

Physician ______________________ Phone ______________________

Address ______________________

Dentist ______________________ Phone ______________________

Address ______________________

Podiatrist ______________________ Phone ______________________

Address ______________________

Attorney ______________________ Phone ______________________

Address ______________________

Pre-Arranged Funeral? ☐ Yes ☐ No Funeral Home ______________________

Address ______________________ Phone ______________________

If no pre-arrangement, funeral home preference ______________________

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HEALTH CARE INSURANCE

Medicare Number ____

Medicare Part A - Hospitalization Effective Date ______________________

Medicare Part B - Medical Effective Date ______________________

Insurance/Supplemental Insurance Information

Insurance Name ____

Insured's ID Number ______________________________ Expiration Date ____________

Policy/Group Number ____

BIOGRAPHICAL AND SOCIAL DATA

Needs/Reason for entrance to community ______________________________

Current family situation and living arrangements ______________________________

What are your special interests and hobbies? ______________________________

Fraternal, social or professional organizations in which you hold membership ______________________

____

Highest education level:____

I hereby declare that all information provided herein is true according to by best knowledge and I understand that this information may be reevaluated at the time of entrance to the Wesbury community.

Date ______________________________ ______________________________
Signature of Applicant

______________________________ ______________________________
Witness Signature of Responsible Party

Wesbury is a continuing care retirement community governed by a 15 member Board of Directors and affiliated with the Western Pennsylvania Annual Conference of the United Methodist Church. Wesbury is organized as a not-for-profit corporation.
Rev. Jan. 2016

CONFIDENTIAL FINANCIAL DATA

NAME ______________________________ DATE ____________________

Income:	Applicant:	Spouse:	Total:
Social Security Payment	$ ________ mo.	$ ________ mo.	$______________
Pension and Retirement	$ ________ mo.	$ ________ mo.	$______________
Veterans Benefits	$ ________ mo.	$ ________ mo.	$______________
Annuities	$ ________ mo.	$ ________ mo.	$______________
Dividends and Interest	$ ________ mo.	$ ________ mo.	$______________
Rental Property	$ ________ mo.	$ ________ mo.	$______________
Other Income	$ ________ mo.	$ ________ mo.	$______________
Total Monthly income	$ ________ mo.	$ ________ mo.	$______________

Assets:	Value	Type/Name on Account
Checking	____________	______________________________
Savings	____________	______________________________
Certificates*	____________	______________________________
Stocks*	____________	______________________________
Bonds*	____________	______________________________
Real Estate *(specify location)*	____________	______________________________
Other	____________	______________________________

Have you gifted any resources in the past 5 years? ______________________________

Veterans Aid and Attendance

Are you a Veteran? ☐ Yes ☐ No Veteran's Spouse? ☐ Yes ☐ No VA Claim No. ____________________

Long Term Care Insurance

Company ______________ Annual cost ______________ Elimination period ______________

Assisted living Coverage ______________ Amount per day ______________ Maximum/ # years ______________

Nursing care Coverage ______________ Amount per day ______________ Maximum/# years ______________

Life Insurance

Company ______________ Type ______________ Policy No. ______________

Beneficiary ______________________________

Cash Value ______________ Death Benefit Value ______________

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Monthly Expenses: Monthly Payment

	Monthly Payment
Auto Insurance	___________________
Health Insurance	___________________
Life Insurance	___________________
Long-Term Care Ins.	___________________
Prescriptions	___________________
Other	___________________

Other Outstanding Debt:

	Monthly Payment	Outstanding Balance
Credit Cards	___________________	____
Mortgage	___________________	____
Car Payment	___________________	____
Other	___________________	____

MEDICAL DATA TO SUPPORT APPLICATION FOR ADMISSION

WESBURY * 31 NORTH PARK AVENUE * MEADVILLE, PA 16335
To be completed by Applicant's current attending physician
and returned to Wesbury Marketing. Fax: 814-332-9436

Name of Patient ____ Age_______

Please list any Allergies or Medication Reactions:
____

Please list any Dietary Restrictions:
____

Past Medical History, Diagnosis and Special Equipment

____

____

____

Physical Examination

Pulse _______Temp. _______ Blood pressure _______Weight_________Skin _________

All Current Medications *(Prescriptions and OTC)*

Medication	Dosage	Frequency

For residents chart, please send copies of doctor office visits, labs, tests, consent notes, etc., *(including vaccine records, x-rays, progress notes, etc.*) within the past 2 years.

Please select appropriate care level

☐ Independent Living – Lives independently with no assistance needed.

☐ Assisted Living – Meals, housekeeping, laundry, transportation, access to nursing, no personal care.

☐ Personal Care – Assistance with bathing, medications, grooming, cueing, etc.
(Must be safe in room and take self to bathroom)

☐ Skilled Nursing – Needs 24 hour nursing care

☐ Memory Support Center **-** Secure (LOCKED) area.

Please indicate

☐ I will attend my patient in the event that he/she is required to relocate to Grace Health Center.

☐ I will refer my patient to another physician in the event that he/she is required to relocate to Grace Health Center.

Date ___________________________

____
Physician's Signature

____
Physician's Name - Print

____
Physician's Address

____
City, State and Zip Code

____
Physician's Phone Number

____
Physician's Fax Number

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