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 Branch: _____

Are you a Wartime Veteran? ☐ Yes ☐ No What Conflict? _____

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. Nov. 2017

CONFIDENTIAL FINANCIAL DATA

Applicant (A) _____ DATE _____

Applicant (B) _____

Monthly Income	Applicant A	Applicant B	Total
Social Security Payment	$	$	$
Pension and Retirement	$	$	$
Veterans Benefits	$	$	$
Annuities	$	$	$
Dividends and Interest	$	$	$
Rental Property	$	$	$
Other Income (specify)	$	$	$
Total Monthly Income	$	$	$

Assets	Joint - Note Area	Applicant A	Applicant B	Total
Checking	$	$	$	$
Savings	$	$	$	$
Certificates of deposit (CDs)	$	$	$	$
Annuities (list type of)	$	$	$	$
Stocks/Bonds	$	$	$	$
Mutual Funds	$	$	$	$
Retirement Funds (IRA, 401K, etc.)	$	$	$	$
Real Estate (specify location)	$	$	$	$
Other (specify)	$	$	$	$
Total	$	$	$	$

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

Branch: _____ Are you a Wartime Veteran? ☐ Yes ☐ No What Conflict? _____

Long Term Care Insurance	Applicant A	Applicant B	
Company			
Annual Cost	$	$	
Elimination Period			
Assisted Living Coverage	$ /day	$ /day	Max./# years
Nursing Care Coverage	$ /day	$ /day	Max./# years
In-Home Care Coverage	$ /day	$ /day	Max./# years

Life Insurance

Company _____ Type _____ Policy No. _____

Beneficiary _____

Cash Value _____ Death Benefit Value _____

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Monthly Expenses that Continue Once at Wesbury	Applicant A	Applicant B	Total
Auto Insurance	$	$	$
Health Insurance	$	$	$
Life Insurance	$	$	$
Long-term Care Insurance	$	$	$
Prescriptions	$	$	$
Food and Gas	$	$	$
Personal (clothing, travel, entertainment etc.)	$	$	$
Utilities (If House is Unsold)	$	$	$
Donations or Tithing	$	$	$
Other Monthly Expenses (specify)	$	$	$
Total	$	$	$

Outstanding Debt	Applicant A Monthly Payment	Applicant B Monthly Payment	Outstanding Balance	Pay Off Date
Credit Cards				
Real estate (Mortgage)				
Other Loans (vehicle, RV, boat, etc.)				
Other (specify)				
Total				

Notes: _____

_____

_____

_____

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

Rev. 01/16