APPLICATION FOR: GRACE REHABILITATION AND HEALTH CENTER

31 NORTH PARK AVENUE
MEADVILLE, PA 16335

Please return to Admissions Coordinator

INDIVIDUAL DATA

Last Name______________________First Name__________________________M.I.____________

Medicare#________________________Effective Date______________________________

Supplemental Insurance___________________________ID#_________________GRP#_____________

Social Security #_____________________________________

Current Address____

City/State/Zip____County____________________

Current Phone #____________________Would you like phone upon admission (Fee $7.50) ☐ Yes ☐No

Date of Birth___/___/____ Place of Birth_____________________Name I like to be called_____________

PHYSICIANS

Primary Physician ____ Phone (   ) _____________

Address ____

Specialist (heart doctor, etc.)____

Dentist _________________________ Eye Doctor___________________________

Podiatrist ___________________________ Last visit______________________

Pharmacy Preference_________________________Hospital Preference___________________________

Ambulance Membership ? ☐ Yes ☐ No Name of Company __________________________________

DEMOGRAPHICS

Sex ☐Male ☐Female Race____________ US Citizen ☐Yes ☐No If No_________________

Marital Status ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated

Veteran ☐Yes ☐No Spouse of a Veteran ☐Yes ☐No Branch______________________________

Dates of Service_________________SN#__________________ Discharge Status_____________

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

____

EMERGENCY CONTACTS

Emergency Contact Name______________________________ Relationship ____________

Address ______________________________Legal Relationship____________

Phone ____________ Bus. Phone ____________ Cell Phone______________

Email______________________________

1st Contact Name ______________________________Relationship ________

Address ______________________________Legal Relationship____________

Phone ____________ Bus. Phone ____________ Cell Phone______________

Email______________________________

2nd Contact Name ______________________________Relationship ________

Address ______________________________Legal Relationship____________

Phone ____________ Bus. Phone ____________ Cell Phone______________

Email______________________________

FUNERAL HOME INFORMATION (Required Information)

Funeral Home of Preference____________________Phone____________________

Address______________________________Pre-Arranged ☐Yes ☐No

RESPONSIBLE PARTY/BILLING PREFERENCES

After admission will resident receive personal mail? ☐Yes ☐No

If No, mail (including monthly bill) is sent to:

Name____________________________Phone______________

Address/City/State/Zip____________________________________

After admission will resident receive business mail ? ☐Yes ☐No Receive Bill? ☐Yes ☐No

If No, mail/bill is to be sent to the following responsible party:

Name______________________________Phone______________

Address/City/State/Zip____

Relationship__________________________

BIOGRAPHICAL AND SOCIAL DATA

Education____________________ Occupation______________________

Spouse________________________ Date Married______________________ Deceased ☐Yes ☐No

Children(names/ages/residences)____

____

____

Previous Living Arrangements ☐Lived Alone ☐Lived with Family ☐Lived with assistance

Previous Home Health Agency_______________________________________

DAILY ROUTINE

What time is bed time? ________________________What time do you get up?______________________

Do you take naps during the day? ☐Yes ☐No Do you go out during the week? ☐Yes ☐No

Do you have any hobbies or daily routines? ☐Yes ☐No

Please list____

Do you spend most of your time alone? ☐Yes ☐No Do you smoke? ☐Yes ☐No

Do you have daily contact with relatives or close friends? ☐Yes ☐No Do you have a pet? ☐Yes ☐No

Do you attend church? ☐Yes ☐No If yes Religion____________________

Church__________________________Pastor_____________________________

Address__________________________Phone____________________________

Would you like cable connection ($15.00 fee) ☐Yes ☐No

NUTRITION PREFERENCES

Do you follow a special diet?____
List your favorite foods____
Specific food dislikes____
Snacks____
Food Allergies____

MEDICAL

Flu Vaccine________________________ Pneumonia Vaccine_______________________

Allergies____

Hearing Aids Right serial #_____________________ Left serial #_______________________________

Glasses_________________ Dentures, upper_____ lower_______, partials, upper_______ lower________

Home Equipment: ☐bedside commode, ☐walker, ☐cane, ☐wheelchair, ☐bed, ☐other___________

AGREEMENT AND AFFIRMATION

I understand and agree that before entering Wesbury United Methodist Retirement Community (hereinafter referred to as "Wesbury") my care needs can be evaluated by authorized personnel at the request of Wesbury.

I understand and agree that, upon admission to Wesbury, I will abide by all rules and regulations of Wesbury including any changes duly announced.

I agree that, upon entrance to Wesbury's Grace Rehabilitation and Health Center, I will secure the services of a physician who will meet the requirements set by federal and state regulations and by those policies adopted by the Board of Directors of Wesbury. This physician must be responsible for regularly scheduled visits and be available on emergency call, or will make provision for coverage in case of an emergency. In the event the attending physician fails to comply with the required visits, I agree that the Medical Director of Wesbury or his designee may and must visit me. Should I be unable to secure the services of a physician, I authorize Wesbury to secure a physician for me. I agree that the physician's care shall be provided at my expense.

I agree to pay the charges for room and care, nursing care, and special services monthly, the rates being subject to change upon a notice of one month in advance.

Should my account at any time become delinquent, I agree to an additional finance charge which will be assessed monthly until the account is in order.

I understand that all drugs, treatments and special services will be provided at my expense in addition to the regular charge of room and care.

After admission to Wesbury, should I require, or desire, special nursing care, I agree that it shall be provided at my expense and instruct the person responsible for my financial affairs to provide for this.

Should I require hospitalization, emergency care, consultation with another medical doctor, diagnostic studies or other treatment upon recommendation of my physician and/or Wesbury, and it is impossible to contact the person indicated as my responsible party, I authorize and agree that I shall be transferred to a hospital at my own expense. Should this require the use of an ambulance or other means of transportation, I agree that the expense will be billed directly to me.

I understand and agree that Wesbury is not responsible for replacing the loss of, or damage to, any of my personal property while I am a resident at Wesbury. Only those items properly identified and placed in the Health Center's depository for security purposes shall be the responsibility of Wesbury.

I understand that a discharge plan will be developed within seven days of admission and will be reviewed and updated on a timely basis while I am a resident at Wesbury.

I understand that when I am permanently discharged from the facility and a bed is no longer reserved for me whether due to death or transfer, my personal belongings will be stored in a storage area for a period not to exceed 30 days. If these items have not been removed within 30 days of the discharge date, they will be disposed of at the discretion of the facility.

Date ____________________________

____
Signature of Applicant

____
Witness

____
Signature of Responsible Party

Wesbury United Methodist Retirement Community is a retirement community governed by a 30 member Board of Directors and affiliated with the Western Pennsylvania Annual Conference of the United Methodist Church, which serves as the corporate body. Wesbury is organized as a not-for-profit corporation. Since the corporation is categorized 501(c)(3) by the Internal Revenue Service, contributions are tax deductible.

Monthly charges may change from time to time as costs increase and will always be the latest revised rate.

Wesbury reserves the right to reject any applicant for admission, without prejudice, unless the application is fully completed and necessary financial arrangements are made.

Changes in room assignments may be made anytime, at the discretion of the administration or nursing staff of Wesbury. The resident and/or responsible party shall be notified prior to any change in room assignments.

Rules and regulations of Wesbury may be changed at any time and, upon proper notification, all residents will be expected to abide by the changes. Special arrangements or exceptions to the rules and regulations will be granted only if, in the judgment of the administration, nursing and medical staff, they are in the best interest of all concerned.

AGREEMENT OF RESPONSIBLE PARTY

In consideration of the admission of ____ as a resident of Wesbury United Methodist Retirement Community, and the continued nursing services rendered as agreed upon, I will be responsible for the prompt payment of all charges made to the account of the applicant.

I have read the statements and conditions printed on the preceding pages of this application, and agree to be bound by the terms stated in the agreement. I will cooperate with the administration and the staff of Wesbury to the fullest extent.

I understand that this agreement will remain in full force until a written notice of its cancellation is authorized by me, or requested by Wesbury.

____
Signature of Responsible Party

Date ______________________

____
Address

Phone (   ) ________________

____

____
Witness

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