APPLICATION FOR: CARE COTTAGE

31 North Park Avenue, Meadville, PA 16335

Please complete form (one per person) and return to the Wesbury at Home 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 your 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 ______________________________

HOME & COMMUNITY BASED SERVICES (HCBS) WAIVER

Type *(Name of Waiver)* ______________________________

Community Health Choice ID # ______________________________ Date of Service ____________

Member Services Phone Number ______________________________

Service Coordinator ______________________________ Phone ____________

Email ______________________________

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

____
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. Feb 2023.