APPLICATION FOR: GRACE REHABILITATION AND HEALTH CENTER

31 NORTH PARK AVENUE
MEADVILLE, PA 16335

Please return to Admissions Coordinator

INDIVIDUAL DATA

Full Name of Applicant _____ Maiden Name _____

Mailing Address _____ Phone ( ) _____

_____ Zip Code _____

Is Applicant a U. S. Citizen? ☐ Yes ☐ No

Age _____ Sex _____ Date of Birth _____ Birthplace _____

Status: ☐ Married - Date _____ ☐ Single ☐ Widowed ☐ Divorced

Former Occupation _____

Spouse _____ Maiden Name _____

Address _____ Phone ( ) _____

If Deceased, Date of Death _____ Power of Attorney (POA) ☐ Yes ☐ No

Name of POA _____ Phone ( ) _____

Person (Responsible Party) to be notified in case of emergency _____

Address _____ Home Phone ( ) _____

_____ Work Phone ( ) _____

Do you have Advance Directives? ☐ Yes ☐ No ☐ Living Will ☐ Do Not Resuscitate ☐ Durable POA

Physician _____ Phone ( ) _____

Address _____

Dentist _____ Phone ( ) _____

Address _____

Podiatrist _____ Phone ( ) _____

Address _____

Attorney _____ Phone ( ) _____

Address _____

Ambulance Membership ? ☐ Yes ☐ No Name of Company _____

Pre-paid Funeral? ☐ Yes ☐ No Funeral Home _____

Address _____ Phone ( ) _____

If no pre-arrangement, funeral home preference _____

FAMILY DATA

Names, addresses and ages of nearest relatives who may be contacted:

1. Name _____ Age _____ Relationship _____

Address _____ Phone ( ) _____

2. Name _____ Age _____ Relationship _____

Address _____ Phone ( ) _____

3. Name _____ Age _____ Relationship _____

Address _____ Phone ( ) _____

* * * * * * * * * *

Father of Applicant _____ Birthplace _____

Mother of Applicant _____ Maiden Name _____ Birthplace _____

Father living? ☐ Yes ☐ No Mother living? ☐ Yes ☐ No

BIOGRAPHICAL AND SOCIAL DATA

Needs/Reason for entrance to facility _____

Current family situation and living arrangements_____

_____

What are your special interests and hobbies? _____

What do you enjoy? _____ ☐ Music ☐ TV ☐ Cards ☐ Games

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

_____

Are you a Veteran? ☐ Yes ☐ No Veteran's Spouse? ☐ Yes ☐ No

VA Claim No. _____

Religious affiliation _____ Church _____

Clergy _____

Address _____ Phone ( ) _____

Highest education level: ☐ Elementary ☐ High School ☐ College and Beyond ☐ Trade School

How did you hear about our facility? _____

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 Nursing 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

Rev 3/2016

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: _____

_____

_____

_____