APPLICATION FOR: GRACE REHABILITATON AND HEALTH CENTER

31 Park Avenue, Meadville, PA 16335

Please complete form (one per person) and return to the Admissions Coordinator

INDIVIDUAL INFORMATION

Full Name of Applicant _____ Nickname _____

Mailing Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Email _____

Gender ☐ Male ☐ Female Race _____ US Citizen ☐ Yes ☐ No If, No _____

SSN _____ Date of Birth _____ Birthplace _____ Age _____

Status: ☐ Single ☐ Married – Spouse's Name _____ Date _____ ☐ Widowed ☐ Divorced/Separated

Are you a Veteran? ☐ Yes ☐ No Veteran's Spouse? ☐ Yes ☐ No Branch: _____

Dates of Service _____ SN# _____ Discharge Status _____

HEALTHCARE 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 _____

PHYSICIANS/PHARMACY/AMBULANCE MEMBERSHIP

Primary Physician _____ Phone _____

Address _____

Specialist (heart doctor, etc.) _____

Dentist _____ **Eye Doctor** _____

Podiatrist _____ **Last Visit** _____

Pharmacy Preference _____ **Hospital Preference** _____

Ambulance Membership? ☐ Yes ☐ **Name of Company** _____

EMERGENCY CONTACTS

Emergency Contact Name _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work phone _____

Relationship _____ Email _____

1ST Contact Name _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship _____ Email _____

2nd Contact Name _____ Home Phone _____

Address _____ Cell Phone _____

City / State / Zip _____ Work Phone _____

Relationship _____ Email _____

FUNERAL HOME INFORMATION (REQUIRED)

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

Address _____ Phone _____

If no pre-arrangement, funeral home preference _____

RESIDENT REPRESENTATIVE/BILLING PREFERENCES

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

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

Name _____ Phone _____

Mailing 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 resident representative:

Name _____ Phone _____

Mailing Address _____

City _____ State _____ Zip _____

Relationship _____

BIOGRAPHICAL AND SOCIAL DATA

Highest education level: _____

Former Occupation(s) _____

Current family situation and living arrangements: ☐ Lives Alone ☐ Lives with Family ☐ Other _____

Previous Home Health Agency? _____

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

_____

DAILY ROUTINE

What time do you go to bed? _____ 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

Religious Facility _____ Denomination _____

Address _____ Clergy _____

NUTRITION PREFERENCES

Do you follow a special diet? _____

List your favorite foods: _____

Specific food dislikes: _____

Snacks: _____

Food Allergies: _____

MEDICAL INFORMATION

Flu Vaccine _____ Covid 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 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 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 72 hours unless previous arrangements are made. If these items have not been removed within 72 hours of the discharge date, they will be disposed of at the discretion of the facility.

_____ _____

Date Signature of Applicant

_____ _____

Witness Signature of Resident Representative

Wesbury is a retirement community governed by a 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 RESIDENT REPRESENTATIVE

In consideration of the admission of _____as a resident of Wesbury, 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.

_____ _____

Date Signature of Resident Representative

_____ _____

Phone Address

_____

_____

Witness

HOW DID YOU HEAR ABOUT US?

☐	**Print Ad**	☐	**Direct Mail**	☐	**Radio**	☐	**TV**	☐	**Referred by a Friend**	☐	**Website**	☐	**Other:**

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 (address)	$	$	$	$
Other (specify)	$	$	$	$
Total	$	$	$	$

Have you gifted any resources in the past 5 years in the amount of $500 or more? ☐ Yes ☐ No

If yes, list when and describe the gift: _____

_____

_____

Do you have a Trust? ☐ Yes ☐ No If yes, please include a copy of your trust with this application.

Notes: _____

_____

_____

_____

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? _____

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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_____

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				

I certify that all information provided is true and accurate. I/We agree to make all listed resources available, as required, to qualify for and/or pay for the requested housing, care, and/or services at Wesbury.

Date _____

_____
Signature of Applicant

_____
Signature of Applicant

_____
Signature of Responsible Party