Misericordia
Nursing & Rehabilitation Center

APPLICATION FOR ADMISSION

I. PERSONAL DATA

Full Name of Applicant _____
Last First MI

Home Address_____ Since _____

Now Residing at_____ Since _____

Date of Birth _____ Place of Birth _____

Age _____ Sex_____ Marital Status (circle one) S M Wid. Div. Sep. Race _____

Name of Spouse _____ Age _____

Address of Spouse _____ If deceased Date of Death_____

Father's Name _____

Mother's Maiden Name _____

Religious Affiliation _____ Name of Church _____

Pastor _____ Phone _____

II. MEDICAL INFORMATION

Name of Physician _____ Phone _____

Last Office Visit _____

Hospital Preference (Check One) York ___ Memorial ___ Date of Pneumovax _____

Transferred from _____ Phone_____

Most Recent Hospitalizations:

	Hospital	Reason	Date
1.	_____	_____	_____
2.	_____	_____	_____

Does Applicant have a Living Will? _____Yes _____No

III. FINANCIAL DATA (ASSETS)

	Bank /Institution	Amount	Name(s) on Account
Savings Account	_____	_____	_____
	_____	_____	_____
Checking Account	_____	_____	_____
	_____	_____	_____

	Bank/Institution	Amount	Name(s) on Account
Mutual Funds	_____	_____	_____
CD's	_____	_____	_____
Stocks	_____	_____	_____
Bonds	_____	_____	_____
IRA	_____	_____	_____
401K	_____	_____	_____

Real Estate owned by Applicant _____Twp/Boro._____

Current Equity Value_____

Whose name is on the deed? _____

Has any real or personal property, including cash been transferred by the applicant within the last five years? __Yes ___No If yes, Amount _____

Explain_____

_____

_____

Who will receive billing and financial information? _____

Address: _____Phone:_____

Medical Expenses

Monthly Health Care Premiums _____

Other _____

IV. INCOME:

Social Security No. _____ Amount_____

Pensions Received: Amount _____ Source _____

Is Applicant a Veteran?_____ Spouse of a Veteran? _____ Which War?_____

Interest Income- Amount _____ Source _____

Other Income _____ Source_____

V. INSURANCE:

Medicare # _____ Hospital (Part A) _____ Medical Part B _____

Medical Supplemental Insurance:Name _____ ID#;_____

Medicare Advantage Plan: Name _____ ID# _____

Medicare Part D Prescription Plan: Name _____ID#_____

Other Medical Insurance: Name of Policy _____Policy #_____

Blue Cross: Contract #_____ Group#_____

Blue Shield Contract #_____ Group#_____

Life Insurance Policy Name: _____ Policy #_____

Name:_____ Policy#_____

Long Term Care Policy Name _____ Policy #_____

Date Policy was Acquired _____Face Value _____ Cash Value_____

VI. FAMILY – Please provide ALL information below

Medical Power of Attorney _____Relationship_____

Home Phone _____ Cell_____ Work_____

Email _____

Financial Power of Attorney_____Relationship_____

Home Phone _____Cell_____ Work_____

Email _____

Name of applicant's Legal Guardian (if applicable) _____

Home Phone_____Cell_____Work _____

Email _____

In case of sickness or death notify _____Relationship_____

Home Phone_____Cell_____ Work_____

To Whom should personal property be released at time of discharge or death?

Name:_____ Relationship:_____

Home Phone _____Cell _____ Work_____

Other Contacts - Please provide ALL information below

Name_____Address _____

Phone_____ Relationship_____

Email _____

Name _____Address_____

Phone_____ Relationship_____

Email _____

Name_____Address_____

Phone_____ Relationship_____

Email _____

Name_____Address_____

Phone_____ Relationship_____

Email _____

V. BURIAL PROVISIONS

Financial Source or Burial Trust Funds_____

Funeral Home _____Phone _____

Cemetery _____

Does Applicant have a Last Will and Testament? _____ Who is Executor? _____

Can you please share how you heard about our services?

- Hospital _____
- Service Provider _____
- Billboards
- Website
- Other: _____

What is the primary reason why you chose our services?

- Location
- Reputation for patient care
- Cost
- Other: _____

Applicant hereby certifies that this information is complete, true and correct to the best of his/her knowledge and belief and that he/she has not intentionally withheld or omitted any requested information. Omission or falsification of information may result in rejection of application, denial of admission, or discharge from this facility.

_____

POA or Legal Guardian Signature

Application Prepared by:_____Date_____

Address _____Phone_____

Relationship to Resident _____