



Date: _____

3001 Lititz Pike, P.O. Box 5093, Lancaster, PA 17606-5093
Admission's Office Phone: (717) 581-4438

More choices. Your choices.



Short Term Rehabilitation Application

Brethren Village does not discriminate on the basis of age; however we do not provide pediatric care.

Please Note: Please answer all questions as completely and accurately as possible. In accordance with our Privacy Policy, by providing your name and contact information, you grant permission for representatives of Brethren Village to communicate with you. Your personal information is strictly confidential and will not be sold or released to other parties.

Personal History

Full Name _____

Address _____ City _____ State _____ Zip _____

Social Security No. _____ Phone _____

Medicare No. _____ Part A Part B Medicaid No. _____

HMO Plan or primary insurance _____
POLICY # _____ GROUP # _____

Medicare Supplement Plan C or better (or above company) _____
POLICY # _____

PACE Card (if applicable) _____
CARD NO. _____ EXPIRATION DATE _____

Primary Health Insurance _____
COMPANY _____ POLICY # _____ GROUP # _____

Long Term Care Insurance _____
COMPANY _____ POLICY # _____ GROUP # _____

Date of Birth _____ Place of Birth _____
MONTH DAY YEAR TOWN/COUNTY/STATE

Are you married? _____ Anniversary Date _____ Single Widowed Separated Divorced

Veteran or spouse of veteran? Yes No Branch of Service _____ Years Served _____

Give the full name of your husband or wife:

Name _____ Maiden Name _____

Address (if living) _____

Children

Name	Address	State	Zip	Phone #

Medical Information

Name of referring physician _____

Address _____ Phone _____

Hospital preference _____

Do you have a Living Will or advance medical directive? _____

Do you have Power of Attorney or Guardian? _____ Name _____

Address _____ Zip _____ Phone _____

Funeral home to be called in the event of death _____

Address _____ Zip _____ Phone _____

Do you use tobacco, alcohol, or narcotics in any form? _____

If yes, explain: _____

Have you ever been a resident in any retirement, mental health or nursing facility? _____

If so, give dates and address of facility _____

How did you learn of Brethren Village? _____

Emergency Information

Persons to be contacted in case of emergency or death

1. Name _____ Relation _____

Home phone _____ Work phone _____ Cell Phone _____

Street _____ City _____ State _____ Zip _____

2. Name _____ Relation _____

Home phone _____ Work phone _____ Cell Phone _____

Street _____ City _____ State _____ Zip _____

3. Name _____ Relation _____

Home phone _____ Work phone _____ Cell Phone _____

Street _____ City _____ State _____ Zip _____

Financial Statement

Who is to be billed for services provided? Name _____

Address _____ Phone _____

Please indicate if this is a joint statement of couple, or of an individual _____

ASSETS		LIABILITIES	
Cash Checking	\$	Notes Payable	\$
U.S. Government Securities		Mortgages, Payable on Real Estate—See Schedule "B"	
Securities—See Schedule "A"		Other Debts —Itemized:	
Savings & Certificates of Deposit			
Real Estate Owned—see Schedule "B"			
Trust Account			
Other Assets—Itemized:			
Total Assets		Total Liabilities	

SCHEDULE "A" SCHEDULE OF STOCKS AND BONDS OWNED	
Description	Market Value

SCHEDULE "B" SCHEDULE OF REAL ESTATE OWNED			
Description of Property & Location	Date of Acquisition	Cost	Market Value

SOURCE OF INCOME (MONTHLY)	
Social Security	\$
Pension	
Annuities	
Dividends & Interest	
Other Income — Itemized	
Total (Monthly Income)	

If I am accepted as a Resident, I hereby agree to enter into a contract to abide by the terms of the Resident Agreement, and agree that if my physical or mental condition should become such as to require special care that the Rehabilitation Center cannot give, provisions may be made for my care as the Administration of Brethren Village may deem best at my cost. I hereby authorize law enforcement agencies to release my criminal records and/or sex offender registration information to Brethren Village or to an agency contracted by Brethren Village to conduct criminal background checks. I hereby authorize health care professionals to release my medical records to Brethren Village. I hereby declare that all information is true to the best of my knowledge.

APPLICANT SIGN AND DATE HERE

Office use only:

Date application received _____

Date application acted upon _____ Action taken _____

Date of admission _____

Initial placement _____