



ADMISSION APPLICATION FOR NURSING CARE: SHORT-TERM REHAB.

Return completed application to: ADMISSIONS phone 717.866.3504 fax 717.866.3291

With the submission of this application, you are applying for a Medicare approved rehab. stay to be limited to the maximum number of days of Medicare eligible expenses. By completing and signing this application you acknowledge that Discharge Planning will begin upon admission to StoneRidge Retirement Living and that if you desire or require a longer stay within the facility, you will be obligated to reapply.

Complete the following information to the best of your ability. Incomplete applications will not be reviewed.

COMMUNITY PREFERENCE (Contingent upon bed availability):

TOWNE CENTRE POPLAR RUN NO PREFERENCE/FIRST AVAILABLE BED

Name of Applicant _____ Date of Birth _____ M F

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Marital Status Single Married Divorced Widowed Spouse's Name _____

Medicare # _____ Insurance _____ ID# _____

RX Insurance _____ Long Term Care Insurance _____

Monthly Income _____ Monthly Liabilities _____ Approx. Value of Liquid Assets _____

Approx. Value of Non-Liquid Assets _____ Reason for Placement _____

Name of Power of Attorney / Responsible Party _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Name of Secondary Contact _____

Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

AUTHORIZATION

In signing this agreement, I certify that the above information is true to the best of my knowledge and understand that this information will be used to determine eligibility for a Medicare-funded stay at StoneRidge Retirement Living.

Signature of Applicant _____ Date _____

Relationship if not Applicant _____