

# APPLICATION FOR ADMISSION

## MEADOW VIEW NURSING CENTER

1404 Hay Street, Berlin, Pa 15530 814-267-4212, fax: 814-267-6213

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Present Address \_\_\_\_\_ Phone \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Are you a Veteran? \_\_\_\_\_  
Receiving Veterans Benefits? \_\_\_\_\_  
Widow of a Veteran? \_\_\_\_\_

Next of Kin or Contact Person: \_\_\_\_\_

Name	Relationship
_____	_____
Address	Phone

Male \_\_\_ Female \_\_\_ Marital Status: Single \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Separated \_\_\_

Spouse birthdate (if applicable) \_\_\_\_\_ If deceased, date of spouse's death \_\_\_\_\_

Can you afford to pay privately the rate of approximately \$6000 per month? Yes \_\_\_\_\_ No \_\_\_\_\_

If not please provide the following payor source information:

Medicare Number: \_\_\_\_\_ Part A? \_\_\_\_\_ Part B? \_\_\_\_\_  
Medicaid? \_\_\_\_\_ # \_\_\_\_\_

Pace Number \_\_\_\_\_ Medicare Prescription Drug Plan \_\_\_\_\_

Insurance Company \_\_\_\_\_

Group # \_\_\_\_\_ ID# \_\_\_\_\_

Other health, prescription, or long-term care insurance? (list name, number, and type)

Hospital Preference: \_\_\_\_\_

How did you hear about Meadow View? \_\_\_\_\_

Any criminal history or psychiatric stays? \_\_\_\_\_

Current Physician \_\_\_\_\_:

Medications: \_\_\_\_\_

Living Will? \_\_\_\_\_

Power of Attorney (y/n) name, address:

*\*A copy of all Insurance cards is needed prior to admittance of any resident.*