Application for Admission

Short-Stay Rehabilitation

at Maplewood Nursing & Rehabilitation

100 Daniel Drive, Webster, New York 14580
(585) 872-1800

THE MAPLEWOOD
Distinctly different.

General Information

How did you learn about us? _____

Name: _____
Last *First* *Middle*

Full Address: _____ Zip Code: _____

County: _____ E-mail: _____

Phone: (____) _____ Cell Phone: (____) _____ Residence: ☐ Own ☐ Rent

Birthdate: _____ /_____ /_____ Sex: ☐ M ☐ F Marital Status: ☐ M ☐ W ☐ D ☐ S

Social Security Number: _____

Traditional Medicare Number: _____ Medicaid Number: _____

NOTE: Please provide copies of ALL insurance cards.

Other Insurance Numbers and Type (MVP, Excellus, BC/BS, etc.): _____

_____

Religion: _____ Church/Synagogue: _____

Special Diet Needs: _____

Smoke: ☐ Yes ☐ No Advanced Directives: ☐ CPR ☐ DNR

Primary Care Physician: _____ Day Phone: (____) _____

Surgeon: _____ Day Phone: (____) _____

Type of Surgery: _____ Date of Surgery: _____ /_____ /_____

Hospital: _____

Legal Counsel: ☐ Yes ☐ No

_____
Firm *Attorney*

Responsible Person(s) to Notify: *(Power of Attorney = POA; Health Care Proxy = HCP)*

1. Name: _____ Relationship: _____ ☐ POA ☐ HCP

Full Address: _____

Phone: (____) _____ E-mail: _____

2. Name: _____ Relationship: _____ ☐ POA ☐ HCP

Full Address: _____

Phone: (____) _____ E-mail: _____

3. Name: _____ Relationship: _____ ☐ POA ☐ HCP

Full Address: _____

Phone: (____) _____ E-mail: _____

In consideration of the admission of the prospective patient named below, I certify that I have knowledge of the named individual's assets and control or authority with respect to the same. I agree to make prompt payment in advance of nursing home charges as billed.

I understand that this agreement is intended for a short term or "Respite" stay and that the maximum length of stay at Maplewood will be 42 days in duration.

I understand that in the event my insurance does not cover my stay at Maplewood Nursing & Rehabilitation I am responsible for charges incurred. (We recommend that individuals check with their medical insurance carrier to obtain rules for coverage in a skilled nursing facility.)

I certify that all the information set forth in this Application for Short Stay Rehabilitation is accurate and complete and that The Maplewood is relying on this information in evaluating me for a Short Stay admission to The Maplewood.

Patient Name (please print): _____

_____ _____

Witness Short Stay Resident's Signature/Date

(OR)

_____ _____

Witness Short Stay Resident's Attorney-in-Fact Signature/Date

MAPLEWOOD NURSING HOME, INC.
d/b/a THE MAPLEWOOD

_____

By: Maplewood Representative

Date:_____