Bethel Home, Eden Meadows, Elijah's Place and Gabriel's Villa
Application for Admission

This information will be utilized in a confidential manner by the professionals assisting you in placement on the Miravida Living campus.

PERSONAL INFORMATION
Name: _____ (Last) (First) (Middle) (Maiden)
Home Address: _____ (Street) (City) (State/Zip) (Phone)
Presently Residing at:
Email Address:
State of Legal Residence:
Date of Birth: Sex: M F
Marital Status: S M W Sep D
Name of Spouse:
Has applicant ever lived in any other retirement or nursing home? Where? When?
When was applicant last hospitalized?
HEALTH INFORMATION

Name of Primary Physician:	Phone:

PERSONS TO BE KEPT INFORMED IN STATUS INCLUDING EMERGENCY, IN THE ORDER THAT YOU WOULD LIKE THEM NOTIFIED

1. Name _____ Address _____ _____ Relationship _____	Phone: Home: _____ Work: _____ Cell: _____ Email: _____
2. Name _____ Address _____ _____ Relationship _____	Phone: Home: _____ Work: _____ Cell: _____ Email: _____

PLEASE COMPLETE THE FOLLOWING (AS APPLICABLE)

POA of Health Care: □ YES □ NO

POA of Finance: □ YES □ NO

Living Will: □ YES □ NO

Guardian:

ADMISSION

Desired date of admission:

Person to contact for admission:	
Name _____ Address _____ _____ Relationship_____	Phone: Home: _____ Work: _____ Cell: _____ Email: _____

What is the anticipated length of stay?

A) Short Term ☐ B) Long Term ☐ C) Respite ☐

INSURANCE INFORMATION

Medicare Number: _____

Medicaid Number (Medical Assistance, Title 19) /Family Care:

Medical Hospital Insurance (Plan A) □ YES □ NO Medicare Medical Insurance (Plan B) □ YES □ NO			
Health Insurance Plan:	Group Number:	ID/Policy number:	
Address of Plan:	City:	State:	Zip:
Phone number:			
ADDITIONAL HEALTH INSURANCE			
Other Health Insurance Plan:	Group Number:	ID/Policy number:	
Address of Plan:	City:	State:	Zip:

In completing this application, I am aware the Miravida Living will rely upon the accuracy of my statements contained herein. I understand I may be requested to update this application when Miravida Living considers it necessary. Therefore, I declare all information provided in this application is true, full and complete.

Name of person completing information (***please print***)_____

Signature of person completing information_____

Date _____

Please return this form to Catharine Tesch, Director of Managed Care, ctesch@miravidaliving.com or send to her confidential fax: (920) 232-5247.

FOR OFFICE USE ONLY

Application received by _____ on_____