



Helen Porter Healthcare and Rehabilitation Center
CONFIDENTIAL APPLICATION



APPLICANT'S NAME: _____ DOB: _____

SEX: M F MARITAL STATUS: _____ RELIGION: _____

PRIMARY M.D.: _____ PHYSICIAN'S PHONE: _____

PRIMARY MEDICAL CONCERN: _____

Reason admission to Helen Porter (ie: long term care, respite, dementia care, rehabilitation to improve lower body strength, etc.) _____

Discharge goals: _____

Estimated length of stay: _____

ALLERGIES: _____

Please name the primary and secondary contacts and their relationship to the applicant (especially if they are an official Power of Attorney).

NAME: _____ ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____ RELATIONSHIP: _____

RESPONSIBLE FOR: MEDICAL DECISIONS _____ FINANCIAL DECISIONS _____

NAME: _____ ADDRESS: _____

CITY/STATE/ZIP: _____

TELEPHONE: _____ RELATIONSHIP: _____

RESPONSIBLE FOR: MEDICAL DECISIONS _____ FINANCIAL DECISIONS _____

FINANCIAL INFORMATION

MEDICARE # _____ SOCIAL SECURITY # _____

MEDICAID # _____ STATE/COUNTY _____

Are you interested in knowing more about Medicaid? Yes No

[OFFICE USE ONLY - potentially eligible? Yes No]
[If so, date application completed? ___/___/___]

DOES THE APPLICANT HAVE ANY OTHER MEDICAL INSURANCE (S)?

NAME OF COMPANY: _____ PHONE #: _____

POLICY #: _____ GROUP #: _____

Does this insurance cover the pharmacy? yes no

(Please attach a copy of both sides of any insurance cards and Advanced Directives)

NAME OF COMPANY: _____ PHONE: _____

POLICY #: _____ GROUP #: _____