THE University of Vermont HEALTH NETWORK

Porter Medical Center

Helen Porter Rehabilitation & Nursing

Application for Admission

Applicant

Last Name: _____ First Name: _____ MI: ____

Sex: □ M □ F Marital Status: _____ DOB: _____

Address: _____ Phone (Home): _____

_____ Phone (Cell): _____

Advanced Directive? □ Yes □ No Social Security Number: _____

Primary Representative

Name: _____ Relationship: _____

Address: _____ Phone (Home): _____

_____ Phone (Cell): _____

E-mail: _____ Phone (Work): _____

Is there a court-appointed guardian? □ Yes □ No If so, date appointed: _____

Is a guardian being recommended/in process?: □ Yes □ No

Power of Attorney? Healthcare: □ Yes □ No Finances: □ Yes □ No

Secondary Representative

Name: _____ Relationship: _____

Address: _____ Phone (Home): _____

_____ Phone (Cell): _____

E-mail: _____ Phone (Work): _____

Alternate Power of Attorney? Healthcare: □ Yes □ No Finances: □ Yes □ No

*****Attach copies of all advanced directives, powers of attorney, and documents establishing guardianship.*****

Primary Care Provider: _____ Phone: _____

Practice: _____ Fax: _____

Address: _____

_____

Primary Diagnosis: _____

Allergies or Other Concerns: _____

Is admission requested for? □ Long-term Care □ Memory Care □ Respite Stay (less than 30 days)

Reason(s) for admission: _____

_____

_____

Has the applicant been hospitalized or in a skilled nursing facility in the past 60 days? □ Yes □ No

Date From: _____ Date To: _____

Facility: _____ Phone: _____

Address: _____ Fax: _____

_____

Reason(s): _____

Financial Information

Medicare Number: _____ Part A: □ Yes □ No Part B: □ Yes □ No

Other Insurance

Company: _____ Phone: _____

Policy: _____ Group: _____

Policy Type: □ Traditional Insurance □ Medicare Supplement □ Medicare Advantage

Medicare Part D or Prescription Coverage

Company: _____ Phone: _____

Policy: _____ Group: _____

Long-Term-Care Insurance

Company: _____ Phone: _____

Policy: _____ Group: _____

Medicaid

Number: _____ State: _____ County: _____

Is a Medicaid application pending? □ Yes □ No In progress? □ Yes □ No

Are you interested in knowing more about Medicaid? □ Yes □ No

*****Attach copies of both sides of all policy membership cards.*****

Printed Name: _____

Signature: _____ Date: _____

Office Use Only

Received By: _____ Date of Receipt: _____