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

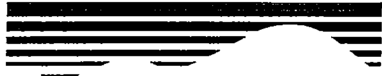
[OFFICE USE ONLY – potentially eligible? _____ Yes _____No]

[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 #:____________________________



Helen Porter
Healthcare and Rehabilitation Center
30 Porter Drive, Middlebury, Vermont 05753

PERMISSION FOR RELEASE OF INFORMATION AND/OR RECORDS

I, ________________________________, hereby give my permission for ________________________________ to release any requested medical information and/or records to Helen Porter Healthcare and Rehabilitation Center in connection with the case of ______________________________.

Signature ______________________________ Date __________________
Relationship to Resident

Witness ______________________________ Date __________________

Original to Agency
Copy for Client
Copy for Case Record