

EMERGENCY CONTACTS:

Cedar Village will contact the first individual listed below. In the event the first person is not available, the second individual will be contacted.

- 1) Name: _____ Relationship: _____
Street: _____ Home Tel #: _____
City: _____ State: _____ Zip Code: _____ Work Tel #: _____
Cell #: _____
- 2) Name: _____ Relationship: _____
Street: _____ Home Tel #: _____
City: _____ State: _____ Zip Code: _____ Work Tel #: _____
Cell #: _____

MEDICAL INSURANCE INFORMATION:

Medicare #: _____ Part A: Yes _____ No _____
Part B: Yes _____ No _____
Medicaid #: _____

Other Insurance Carrier: _____ Plan Code: _____ Policy #: _____
Address: _____
Insurance is paid by whom: _____

Other Insurance Carrier: _____ Plan Code: _____ Policy #: _____
Address: _____
Insurance is paid by whom: _____

Long-term Care Insurance Policy Yes _____ No _____ (if yes, obtain copy of policy)
Carrier: _____
Address: _____
Insurance is paid by whom: _____

Copy of Insurance Cards Obtained (both sides): Medicare _____ Medicaid _____ Secondary _____

PHYSICIAN PRIOR TO ADMISSION:

Physician's Name: _____
Street: _____ Telephone #: _____
City: _____ State: _____ Zip Code: _____

PHYSICIAN TO FOLLOW AT CEDAR VILLAGE:

Physician's Name: _____ Hospital Preference: _____
Street: _____ Telephone #: _____
City: _____ State: _____ Zip Code: _____

LEGAL INFORMATION (copies are needed if applicable)

The individual listed will be the contact for the applicable document:

Living Will:	Yes _____ No _____	Name: _____	Home Tel #: _____
			Work Tel #: _____
			Cell #: _____
Durable POA Health Care:	Yes _____ No _____	Name: _____	Home Tel #: _____
			Work Tel #: _____
			Cell #: _____
Power of Attorney:	Yes _____ No _____	Name: _____	Home Tel #: _____
			Work Tel #: _____
			Cell #: _____
Legal Guardian:	Yes _____ No _____	Name: _____	Telephone #: _____
			Work Tel #: _____
			Cell #: _____

RELIGIOUS AFFILIATION:

Religious Preference: _____

If Jewish: Reform _____ Conservative _____ Orthodox _____

Congregation: _____

Spiritual Leader: _____ Telephone #: _____

Family's Congregation: _____

If Jewish: Hebrew Name: _____

Mother's Hebrew Name: _____ Date of Passing (Yahrzeit): _____

Father's Hebrew Name: _____ Date of Passing (Yahrzeit): _____

Other Information / Comments: _____

I (We), the undersigned, submit this application to Cedar Village for evaluation for admission. I (We), affirm that to the best of my knowledge all the foregoing information is complete, accurate, and truthful. I (We) agree to notify Cedar Village immediately and without delay if any change occurs that alters my (our) financial ability to perform under such agreement. I understand that this statement is confidential and will be used only as a tool for evaluating my (our) capacity to enter Cedar Village.

I also hereby expressly authorize and request that all physicians, hospitals, health care facilities and providers, or others who have knowledge of me as a patient to give complete and detailed information regarding my health history to Cedar Village, or its accredited representatives.

Applicant: _____ Date: _____

Sponsor/Legal Guardian: _____ Date: _____

Date Application Received: _____	
Time Application Received: _____	
Admission Date: _____	Arrival Time: _____
Room #: _____	From: _____