Masonic Village at Elizabethtown/ Short-term Rehabilitation Application
The Masonic Village is a SMOKE FREE community
Office 1-800-422-1207/Fax: 717-361-5500/www.masonicvillages.org

PERSONAL HISTORY

Name:_____ Phone:_____
Address: _____
City_____ State_____ Zip_____

Date of birth:_____ US Citizen: __Yes __No Sex: __Male __Female
Marital Status:_____ Spouse's Name:_____
Social Security Number:_____ Medicare Number:_____

Please check off if you have: __ Financial POA __Healthcare POA __ Living Will __Last Will/Testament
Legal Power of Attorney's Name:_____ Relationship:_____
Address:_____
Phone: (H)_____(W)_____(C)_____

Are you affiliated with a Pennsylvania Mason or member of the Eastern Star? __Yes __No
If yes, list your relationship to Mason/OES member & their name _____

Name of Family Physician: _____Phone:_____

EMERGENCY CONTACT INFORMATION

1. Name:_____Relationship:_____

Address:_____

Phone: (H)_____(W)_____(C)_____

2. Name:_____Relationship:_____

Address:_____

Phone: (H)_____(W)_____(C)_____

Previous admission to hospital and/or skilled nursing facility this year? __ Yes __ No

Hospital/Facility_____ Dates of Stay:_____

Reason for admission:_____

Hospital/Facility_____ Dates of Stay:_____

Reason for admission:_____

SALES/TRANSFERS/GIFTS

Within the past 5 years, immediately preceding the date of this application, have you or your spouse:

Paid bills for anyone other than yourself from your accounts? __Yes __No
Shared accounts with someone other than your spouse? __Yes __No
Placed assets into a Revocable or Irrevocable Family Trust? __Yes __No
Transferred or gifted real estate, automobiles, bank acct, stocks/bonds, life ins. or other assets? __Yes __No
Sold real estate, automobiles or other assets under Fair Market Value? __Yes __No
Had money or personal possessions taken without your permission? __Yes __No

HEALTH INSURANCE

If health/prescription drug insurance is thru previous/current employer, please list name of employer:

_____

PLEASE INCLUDE COPIES OF THE INSURANCE CARDS LISTED BELOW WITH THE APPLICATION

Primary Medical Insurance: _____

Name as it appears on Insurance Card _____

Agreement/Policy Number _____

Effective Date of Coverage _____

Secondary Medical Insurance: _____

Agreement/Policy Number _____

Effective Date of Coverage _____

Drug Prescription Insurance or PACE: _____

Agreement/Policy Number _____

Effective Date of Coverage _____

My signature acknowledges that this application is for Short Term Rehabilitation only and not Long Term Care placement. All information has been provided to the best of my knowledge. I understand that any misrepresentation or willful omission of information on this application will disqualify the applicant for admission and may be cause for discharge if discovered after resident's admission.

Signature of Applicant and/or person completing this application: _____

Relationship to Applicant: _____ Date: _____

A Masonic Village staff member will contact you regarding the application within one business day of its receipt. Please have the following items available upon admission:

Social Security Card
Medicare Card
Primary or Supplemental Insurance Card
Drug Prescription Card
Photo ID, such as driver's license or passport
Power of Attorney
Living Will

Masonic Village Financial Disclosure Form/Short-term Rehab

Fax: 717-367-5813
One Masonic Drive
Elizabethtown, PA 17022

Resident Name:_____ Date of Admission:_____

Please complete & return this form to the Finance Office at the fax number above by :_____

****A representative from the Finance Office will be calling you within 3 days of admission to review. If you have any questions prior to review, please call (717)-367-1121 x 33209 or 33461. You can also fax completed form to 717-367-5813****

MONTHLY INCOME	**APPLICANT**	**SPOUSE**
Social Security	$	$
Pension	$	$
IRA	$	$
Annuities	$	$
Other	$	$

ASSETS	**APPLICANT**	**SPOUSE**	**√ if joint**
Checking	$	$	
Savings	$	$	
Money Market	$	$	
Certificates of Deposit	$	$	
IRA	$	$	

Have you sold transferred or gifted a home, land, personal property or other resources in the last 60 months/5 years? **N___Y ___** (please describe)

_____

_____

Do you have any shared bank, investment or any other accounts? **N___Y___** (with whom)

_____

What is the discharge goal for the patient? _____

Signature of Applicant and/or person completing this application:_____

Relationship to Applicant:_____Date:_____