WESTHAVEN COMMUNITY

"A MINISTRY OF THE EVANGELICAL CHURCH"

ADMISSION APPLICATION

Westhaven Community is a non-smoking campus

FULL NAME OF APPLICANT: _____

Address _____

City _____ State _____ Zip Code _____

Phone No: _____ Social Security Number: _____

Date of Birth: ___/___/_____ Place of Birth: _____

Marital Status: M____ S____ SEP_____ D_____ W_____

Name of Spouse: _____

If deceased, date of death: ___/____/_____

Profession/Career: _____

Person Responsible for Funeral Arrangements:
Name: _____ Phone: _____
Funeral Director's Name: _____ Phone: _____
Address: _____ Burial Agreement? __ Yes __ No

Military Experience: __ Yes __ No Branch: _____
WWII __ Korean __ National Guard __ Other _____
From: _____ To: _____ Honorable Discharge: __ Yes __ No
(mm/dd/yyyy) (mm/dd/yyyy)

Church Affiliation:
Name of Church: _____ Address: _____
Name of Minister: _____ Phone: _____

Insurance Information:
Medicare Number: _____ **Health Ins**._____
Ins. Number: _____ Phone: _____
Long Term Care Insurance Co: _____
Policy Number: _____ Elimination Period: _____
(#of days waiting period)
Daily payment (Per Diem): _____

Please Note: ALL SECTIONS of this application form must be filled out completely and it must be signed prior to Westhaven Community consideration for admission.

General Medical Information:

Upon admission, residents must have a consenting local (Boone) physician.

Physician Name (must choose a Boone doctor):
Address:
Phone:
Dentist Name:
Address:
Phone:
Optometrist Name:
Address:
Phone:
___ Yes ___ No Are you currently using VA medications?
Westhaven Community uses **Medical Associates** as its Pharmacy

Please list all medications taken at home including supplements.

Medications Taken At Home (including over the counter medications)					
Medication	Dose	How Often	Medication	Dose	How Often

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FINANCIAL RECORD:

	$ Amount	Comments/Explanation
Social Security		
Railroad Retirement		
Veterans Pension		
IPERS		
Annuities		
Other Income		
Value of Home/Farm		
Savings and/or investments		
Trust Fund		
Total Assets		

Contact for Billing Information: _____

In Case of an Emergency Please Notify:

1st Contact

Name: _____ Relationship: _____
Address: _____ Phone: _____

2nd Contact
Name: _____ Relationship: _____
Address: _____ Phone: _____

3rd Contact
Name: _____ Relationship: _____
Address: _____ Phone: _____

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I certify that to my knowledge all information included in this application is true and accurate.

_____ _____
Applicant Signature/Representative Date