BROOKE GROVE RETIREMENT VILLAGE

PRE-ADMISSION INFORMATION

Name

- ❒ Independent Living
- ❒ The Meadows Assisted Living
- ❒ The Woods Assisted Living
- ❒ Brooke Grove Rehabilitation & Nursing Center

Please tell us how you heard about Brooke Grove.

Please include copies of the following:

- The front and back of the Medicare card and all other insurance cards (including pharmacy plan cards)
- Copies of any Power of Attorney documents
- Copies of any Guardianship documents
- Copies of Living Will and Advance Directives

This form and all documents may be faxed to us at 301-924-1591 or emailed to your retirement counselor or admissions coordinator. If you prefer, we can copy them for you in the admissions office.

Admissions Office Phone: 301-260-2320
18121 Slade School Road, Sandy Spring, MD 20860

BROOKE GROVE
RETIREMENT VILLAGE

Application for Residency or Admission

GENERAL

Prospect Name: _____
First Middle Last (Maiden Name if applicable)

Current Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email: _____

Gender: ❒ Male ❒ Female **Marital Status:** ❒ Never Married ❒ Widowed ❒ Divorced ❒ Married

***Religion:** _____ ***Race:** _____ ***Ethnicity:** _____

***Highest Level of Education:** _____ **Lifetime Occupation:** _____

Primary Language: _____ **Language 2:** _____

Date of Birth: _____ **U.S. Citizen:** ❒ Yes ❒ No **Veteran:** ❒ Yes ❒ No

Birth City: _____ **Birth State:** _____

Prospect is now at: ❒ Home ❒ Hospital ❒ Other _____

Has the prospect been admitted to a hospital or other nursing or rehabilitation center within the last year? ❒ Yes ❒ No

If yes, where: _____ Dates: _____

Has the prospect ever been enrolled in the following? ❒ Hospice ❒ Home Care

PHYSICIAN

Primary Care Physician: _____

Phone: _____ **Fax:** _____

Other Physicians: _____

Preferred physician, if community physician does not attend at Brooke Grove: _____

Date of last influenza vaccine: _____ **Pneumonia vaccine:** _____ **Shingles vaccine:** _____

INSURANCE

Social Security #: _____ **Medicaid #:** _____

Medicare #: _____ ❒ A ❒ B **Is Medicare primary?** ❒ Yes ❒ No

Medicare Advantage Plan or Other Insurance: _____

HMO? ❒ Yes ❒ No **Policy #:** _____

Address: _____

Secondary Insurance: _____ **Policy #:** _____

Pharmacy or Medicare D Plan: _____ **Policy #:** _____

Does prospect have Long-term Care Insurance? ❒ Yes ❒ No

_____
Provider

**Optional information requested by Medicare*

FINANCIAL CONTACT

Financial Contact Information (this is only for where bills should be sent)**:**

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Fax: _____ Preferred method of contact: _____

Check all that apply: ❒ Financial POA ❒ Healthcare POA ❒ Guardian ❒ Emergency Contact

If prospect is not able to sign admission paperwork, who will do so? _____

EMERGENCY CONTACTS

Primary Emergency Contacts (in order of priority)**:**

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Check all that apply: ❒ Financial POA ❒ Healthcare POA ❒ Guardian ❒ Emergency Contact

Name: _____ Relationship: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Check all that apply: ❒ Financial POA ❒ Healthcare POA ❒ Guardian ❒ Emergency Contact

Does prospect have an Advanced Directive? ❒ Yes ❒ No (*Please provide a copy of these documents.*)

Please list anyone else with whom we have permission to share medical information:

_____

Please provide copies of all Power of Attorney, Advance Directives or Guardianship documents.

I hereby certify that to the best of my knowledge and belief, the above stated information is correct and complete. I understand that Brooke Grove Retirement Village may, at its sole discretion, void the facility agreement if any information is falsely represented.

I understand that I may not have been asked to provide complete financial information at this time. If Brooke Grove Retirement Village should determine that additional information is required, I agree to provide complete and accurate financial information without delay.

I authorize Brooke Grove Retirement Village to disclose information contained in this form or the facility agreement to facilitate application and/or coordinate benefits from Medicare, Medicaid and other payers.

Prospect or Responsible Party Signature: _____ *Date:* _____

Retirement Counselor or Admissions Coordinator Signature: _____ *Date:* _____