BIRCHWOOD TERRACE
REHAB AND HEALTHCARE

"WE ARE FAMILY"

CONFIDENTIAL APPLICATION

1. General information concerning prospective resident:

A. Applicant

Name:________________________ Date of Birth: ____________
Address:______________________ Social Security # ____________
________________________ Telephone: ____________
Physician: ________________________ PCP Telephone: ____________

B. Individual responsible for paying bills

Name:____________________ Relationship to Resident: ____________
Address: ____________________
____________________ Telephone: ____________

C. Has anyone been appointed power of attorney or guardian? Yes__No____
(Please provide a copy)
If so, who?________________________ Financial and/or Medical Decisions (circle)

D. Additional relatives (significant others) that we may contact, if necessary :

Name:____________________ Relationship to Resident: ____________
Address: ____________________
____________________ Telephone: ____________

Name:____________________ Relationship to Resident: ____________
Address: ____________________
____________________ Telephone: ____________

2. Financial information concerning prospective resident:

Medicare #: ____________ Part A: Yes/No Part B: Yes/No Part D: Yes/No

Other Health Insurance: ____________ Policy # ____________

Long Term Care Insurance: ____________ Policy # ____________

Has the prospective resident applied, or will they be applying shortly, for State Medical Assistance?
Yes_________No_________Medicaid #____________________
If prospective resident has applied, what was the date: ________________

43 STARR FARM ROAD
BURLINGTON, VT 05408
P: 802.863.6384
F: 802.865.4516
REHABILITATION • NURSING • RECOVERY
BIRCHWOODTERRACE.COM

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Monthly Income:

Social Security: ______________________
Supplemental Security: ______________________
Retirement/Pension ______________________
Rental Income: ______________________
Annuities/Investment: ______________________

Real Estate Assets:

Does the prospective resident own a home? Yes_____No_____
Approximate Value: $______________________

Is a property owned jointly? Yes_____No_____

Name of Co-owners: ______________________

Other Assets:

Savings Account: $______________________
Checking Account: $______________________

Please list other assets and their values, such as stocks, bonds, life insurance with a cash value, cd's, etc:

____
____
____
____

Has prospective resident (in the past 60 days) been in the hospital or another healthcare facility?

Yes____No____If yes, please provide us with the name of facility and phone number: _________________

I hereby state to the best of my knowledge and belief, that the above stated information is true, correct and complete. I understand that if any information has been falsely represented, this will be sufficient cost for voiding my application for admission. I also understand that Birchwood Terrace considers this application as a continuing statement of financial condition. All of the information will be kept strictly confidential by Birchwood Terrace and will not be released without my written permission.

I hereby authorize my physician, hospital or nursing facility to release information from my health record. I understand this consent can be revoked at any time.

Applicants Name: ____

Signature of the Applicant/Responsible Party: ____

Date:__________________________________

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