



Nursing & Rehabilitation Center

PRE-ADMISSION APPLICATION

Short Term Subacute Rehabilitation Long Term Skilled Nursing Care
Please Check One

1. Name of Applicant _____ Male Female
2. Address _____ Telephone No. _____
City _____ State _____ Zip _____ Country _____
3. Birthdate _____ Age _____ Birthplace _____ Citizenship _____
4. Marital Status (check one) Married Single Widowed Divorced SS# _____
5. Do you live alone? Yes No Name of Spouse _____
6. Religion _____ Church _____ Primary Language _____
7. Are you a Veteran? Yes No Spouse of a Veteran? Yes No Lifetime Occupation _____
8. Primary Physician _____ Telephone # _____
Address _____
9. Surgeon's Name _____ Telephone # _____
Address _____
10. Date of Surgery _____ Procedure _____ Hospital _____
11. Upon admission to Brothers of Mercy, will the applicant come from:
Private Home _____ Nursing Home (name) _____ Other (name) _____
12. Has the applicant been in any Rehabilitation and/or Nursing Home in the past five years? Yes No
If yes, where _____ : From _____ To _____
13. Emergency Contact _____ Relationship _____
Address _____
Home Phone _____ Business Phone _____
14. Secondary Contact _____ Relationship _____
Address _____
Home Phone _____ Business Phone _____

Experience and Results You Can Trust!

10570 Bergtold Road • Clarence, New York 14031-2198 • (716) 759-6985 • Fax (716) 759-6223
www.brothersofmercy.org

Applicant's Name _____

15. Power of Attorney Yes No Conservator Yes No Bank Power of Attorney Yes No
Name _____ Phone _____
Address _____

16. Funeral Home _____ Phone _____
Address _____

Please assign a Funeral Home when applying for Long Term Care

17. Organ Donor Yes No Health Care Proxy Yes No Living Will Yes No DNR Yes No
If you said yes to any of the above, please provide a copy upon admission

18. Who recommended Brothers of Mercy to you? Family Friend M.D. Reputation Other

Confidential Financial Information

Medicare Number _____ Part A ___ Eff. Date _____ Part B ___ Eff. Date _____

Medicaid Number _____ County _____ Pending Application/Date Submitted _____

Primary Insurance _____ Policy Number _____ Group No. _____

Secondary Insurance _____ Policy Number _____ Group No. _____

Other Insurance _____ Policy Number _____ Group No. _____

Do you own your home? Yes No Do you own any Real Estate? Yes No

Are you currently in a lease or rental situation? _____

Amount of monthly income: Social Security _____ VA _____ Pension _____

Other _____ (specify) _____

Savings Account \$ _____ Checking Account \$ _____

\$ _____ \$ _____

Value of: Marketable Stocks, Bonds, Mutual Funds, etc. \$ _____

Expenses incurred while at Brothers of Mercy Nursing & Rehabilitation Center, which are not covered by Medicare, Medicaid or other health insurance, will be paid from the resources of the applicant. The following individual/designated representative will take full responsibility for insuring that payment will be made from the resources of the applicant.

Signature of Applicant _____ Date _____

Designated Representative (Please Print) _____

Designated Representative (Signature) _____ Date _____

Title (i.e. Power of Attorney, Attorney, etc.) _____

Federal and State Law prohibits this facility from discrimination in admission, retention and care of patients based upon race, creed, color, national origin, blindness, hearing impairment, disability, sex, sexual preference, marital status, religion, age, source of payment or sponsors.