Date of Application: _____

Greenway terrace

ADMISSION APPLICATION

General Information

Name:_____ Gender:_____

Current Address: _____

DoB: _____ SS#: _____

Medicare #: _____ Supplemental Insurance: _____

If Joint Application:
Name: _____ Gender:_____

Relationship to primary applicant: _____

DoB:_____ SS #: _____

Medicare #: _____ Supplemental Insurance: _____

Emergency Contacts:
In case of emergency, who should we contact:

1_____ _____
Name & Relationship Phone (cell/work)

_____ _____
Address e-mail

2_____ _____
Name & Relationship Phone (cell/work)

_____ _____
Address e-mail

3_____ _____
Name & Relationship Phone (cell/work)

_____ _____
Address e-mail

Date of Application: _____

Medical Contact Information:

Primary Physician: _____

_____
Physician Affiliation/Address

_____ _____
Phone email or other contact info

Secondary Physician: _____

_____
Physician Affiliation/Address

_____ _____
Phone email or other contact info

_____ Phone: _____
Choice of hospital if necessary

_____ Phone: _____
Eye Doctor

_____ Phone: _____
Dentist

_____ Phone: _____
Pharmacy (If medication assist required, pharmacist must be SG Pharmacy)

Health Care POA: _____ (Copy must be kept on file)

Phone: _____ Email:_____

Relationship:_____

Power of Attorney for healthcare must not be activated for admission to terrace as required by law unless the person admitted shares the unit with a person that has legal responsibility for the individual.
I verify that the data in this application is accurate to the best of my knowledge:

_____ _____
Applicant Joint Applicant

Dated: _____

A $1,000 deposit is required to hold a unit.

Permission Consent Form

I hereby grant permission to River Valley Nursing Home, Inc. - Greenway Manor/Greenway Terrace (Company) to use or publicly display my photograph, video image (including streaming video) or audio clip on the company website, individual web pages, social media including but not limited to facebook and other company publications without further notice. I acknowledge the company's right to crop, edit or treat the photograph, video or audio clip at its discretion.

Dated: _____

Printed/Typed Name:

Resident Name: _____

Activated PoA for Healthcare Name: _____

Signed:

_____

Resident

_____

PoA for Healthcare