Tuscola County Medical Care Community

Your Care Partner in Skilled Nursing and Rehabilitation Therapy

1285 CLEAVER ROAD ♦ CARO, MICHIGAN 48723
PHONE (989) 673-4117 ♦ FAX (989) 673-6665

ADMISSION APPLICATION

Original Application Date _____

Name_____ **Phone ( )**_____ **Date** _____

Home Address_____

Street City State Zip County

SEX: F M AGE ____ **DOB: M**___**D**___**Y**_____ **Social Security #**___ - ___ - ____**Religion**_____

Place of Birth_____ **Civil Status:** _____ **Occupation**_____

Military service? yes _____ **no U.S. Citizen yes no Primary Language** _____

Primary Care Physician_____

Name Phone

Specialty Physician _____

Name Specialty Phone

Prior Hospice Services _____

Company Name Dates of Service

Funeral Home Choice_____

Name City State Phone

INSURANCE INFORMATION: ***MUST PROVIDE ALL INSURANCE CARDS UPON ADMISSION***

Medicare No._____**(Effective dates)Hospital Ins.(A)**_____**Medical Ins.(B)**_____

Medicare Part D Plan _____ **Medicaid No.**_____

Blue Cross No._____ **Group No.**_____**VA Status and No.**_____

Other Insurance's_____

Income: Soc. Sec. $_____**S.S.I. $**_____**Other**_____

Does applicant have a DPOA, DMPOA, or Guardian? Yes No *Must provide copies upon admission

Name of person responsible for patient's payment to the Medical Care Facility:

1._____

Name Street City State Zip Relationship Phone

Person to contact in case of emergency:

1._____

Name Street City State Zip Relationship Phone

2._____

Name Street City State Zip Relationship Phone

3._____

Name Street City State Zip Relationship Phone

PRIVATE PAY PATIENT'S: **A deposit of $2100 is required on day of admission. This money is to be left on deposit until patient is discharged.**

MEDICAID PATIENT'S: **The patient pay amount will be taken out of Social Security checks, Pension checks, and/or Retirement checks.**

SIGNED:_____ **DATE:**_____

Resident Name	Medical Record #	Room #	Physician	Adm Date