SHORT TERM REHABILITATION
PRE-ADMISSION APPLICATION INSRUCTIONS

Brookside Care Center
3506 Washington Road
Kenosha, Wisconsin 53144
(262) 653-3800 Office (262) 653-3850 FAX

ADMISSION PROCESS:

1. Complete the attached "**SHORT TERM REHABILITATION PRE-ADMISSION APPLICATION**," and return it to the Admissions/Marketing Coordinator.

2. **This form is to be used only for individuals that desire a short term rehabilitation** stay at Brookside Care Center following an elective or scheduled hospital admission or other circumstances that qualify for a short term rehabilitation admission. The Long Term Care Pre-Admission Application must be completed for individuals whom desire long term placement.

3. Return the completed application to the Admissions/Marketing Coordinator with copies of the following documents:
   - Medicare Card
   - Health Insurance Card(s)

4. Upon admission to the hospital, inform your assigned Social Worker of your desire to rehabilitate at Brookside Care Center.

5. Residents are accepted for admission to Brookside Care Center based on the type of care required and bed availability based upon the type of care required.

6. Residents are accepted for admission to Brook side Care Center regardless of sex, race, religion, national ancestry, age, handicap, or any other disability.

7. Brookside Care Center is a Kenosha County facility; therefore, admission priority is given to Kenosha County residents.

8. Brookside Care Center does not hold any insurance provider contracts, therefore; when verifying insurance benefits request provider network status.

9. Brookside Care Center **does not accept** individuals enrolled in the **Family Care/Community Program**.

10. In the event a short term stay would be extended beyond the covered Medicare and/or covered insurance days, please note our **daily rate for room and board (effective 1/1/14) is $300.00**.

11. **Please contact the Admissions/Marketing Coordinator if your scheduled hospital admission has been cancelled.**

Retain this page for your records.

If you have any questions regarding the admission process, please contact:
Diana Christofferson, Admissions/Marketing Coordinator (262) 653-3881

Name:_____ Date of Application:_____

SHORT TERM REHABILITATION
PRE-ADMISSION APPLICATION

Brookside Care Center

For Office Use:
BCC Admit Date:_____
Room#:_____ MR#:_____
SW:_____ Transport:_____
Adm Note:___ SH:___ Photo:___

ADMISSION INFORMATION:

Projected Admission/Surgery Date:_____ Hospital: _____

Admission Reason/Surgical Procedure: _____

Primary MD: _____ Consulting MD Surgeon:_____

Name:_____ Date of Birth: _____
First Middle Last

Home Address: _____
Street City State Zip

Home Phone:_____ Cell Phone:_____

Gender: ☐ Male ☐ Female Marital Status: _____ Race / Ethnicity:_____ Primary Language:_____

Have you been hospitalized within the last 6 months? ☐ Yes ☐ No In a SNF within the last 6 months? ☐ Yes ☐ No

Where?_____When?_____Why?_____

BILLING INFORMATION:

Social Security #: _____Medicare #:_____

Medicaid/T-19? Yes___ No___ If yes: Medicaid/T-19 #:_____

If no, is there a Medicaid/T-19 appointment pending? Yes___ No___

Health Insurance:_____
Company Phone Number

_____
Insured Name ID # Group #

PERSONAL INFORMATION:

Occupation: _____ State/County/City of Birth: _____

Religion: _____Church Affiliation:_____ Funeral Home:_____

Education**:** No Schooling___ 8th Grade/Less___ 9-11 Grades___ High school___

Technical or Trade School___ Some College___ Bachelor's Degree___ Graduate Degree___

Military Service: ☐ Yes ☐ No Branch_____ War Veteran _____

CONTACT INFORMATION:

Is there a POA for healthcare? ☐ Yes ☐ No POA activated? ☐ Yes ☐ No Living Will? ☐ Yes ☐ No
Is there a POA for finance? ☐ Yes ☐ No

*Indicate primary and alternate agents below.

(1) _____
Name Relationship

_____ Home Phone _____
Address Cell Phone _____
Work Phone _____

(2) _____
Name Relationship

_____ Home Phone _____
Address Cell Phone _____
Work Phone _____

Notes:

_____

_____

_____

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