Mohawk Meadows™
Rehab & Nursing Center

INQUIRY FORM

NAME:_________________________________ DATE OF BIRTH:_____________________

ADDRESS: ____

BIRTHPLACE:__________________ MARITAL STATUS: ____________ RELIGION: ______________

MEDICARE #: _________________________ A: _____________ B: _______________

PART D:______________________________ SOCIAL SECURITY#_________________________

MEDICAID#_________________ APPLICATION DATE:_______________ COUNTY _____________

PRIVATE FUNDS_____________________ MEDICAID CASE WORKER__________________________

ADDITIONAL HEALTH INSURANCE **(COPY OF CARD REQUIRED)** ______________________________

____

PATIENT CURRENTLY AT _________________________ DOCTOR'S NAME: ______________________

DOES APPLICANT HAVE PREPAID BURIAL? **YES** **NO**

FUNERAL HOME: __________________________________ BURIAL PLOT ______________________

DOES APPLICANT HAVE A LIVING WILL/ADVANCED DIRECTIVE **YES** **NO (COPY REQUIRED)**

WHO WILL BE FILLING OUT THE ADMISSION PAPERWORK: ____________________________________

PRIVATE BILLING ADDRESS: ____

EMERGENCY CONTACTS: PHONE NUMBERS:

1. NAME: ___________________________________ HOME: __________________________
   ADDRESS: ______________________________ CELL: ___________________________
   WORK: __________________________
   EMAIL: ____

2. NAME:________________________________ HOME:____________________________
   ADDRESS: ____________________________ CELL: ____________________________
   WORK: ____________________________
   EMAIL: ____

OFFICE USE: SUBACUTE___________________ PAS____________________ YES NO

1 O'Brien Lane Lafayette, NJ 07848
Phone: 973-363-9100 - Fax: 973-314-8801
www.mohawkmeadowsrehab.com

Mohawk Meadows™

Rehab & Nursing Center

RE:_________________________________ SSN #

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ID # ________________________________

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I authorize payment of medical benefits to MOHAWK MEADOWS REHAB AND NURSING CENTER.

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SIGNATURE

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