

APPLICATION FOR ADMISSION

- Please check appropriate box: Heritage Manor Nursing Home
 Southgate at Ramapo Ridge
 The Longview Assisted Living Residence
 Hillcrest Residence

Referred by: _____

I. General information regarding prospective resident

A. Applicant's name _____ Male _____ Female _____

Home address _____ Telephone # _____

City _____ County _____ State _____ Zip _____

Applicant's date of birth _____ Age _____ Social Security # _____

Applicant is currently at home _____ hospital _____ nursing home _____ other _____ How long? _____

Please identify location:

Name _____ Telephone # _____

Address _____

Applicant's birthplace* _____ Is the applicant a US citizen? Yes _____ No _____

*Please provide citizenship papers if applicant was born outside of the United States.

Primary language: English _____ other _____

Is the applicant currently employed? _____ Yes _____ No _____

Education _____ Past occupation _____

Religion _____ Church _____

Church location/town _____ Pastor _____ Telephone # _____

Address _____

Marital status _____ Spouse's name _____

Room preference: Private _____ Semi _____

Hospital preference _____

Is the applicant aware of the application and agreeable to placement? Yes _____ No _____

Can the applicant be contacted regarding the status of the application? Yes _____ No _____

Does the applicant have a living will/advance directive? Yes _____ No _____

(If yes, copies are required with application.)

Does the applicant have a medical power of attorney?
(If yes, copies are required with application.)

Yes____ No____

Is the applicant currently a smoker?
(CHCC is a smoke-free facility.)

Yes____ No____

Funeral/burial arrangements:

1. Name of funeral home: _____

Address _____ Telephone # _____

Name of cemetery _____

Address _____

Telephone #: _____ Are the arrangements pre-paid? Yes____ No____

2. Organ donation: Yes____ No____ (If yes, please provide copy of organ donation card.)

Contact name _____ Telephone # _____

B. Financial guarantor (party responsible for making payment)

Name _____ Relationship to applicant _____

Address _____ City _____

County _____ State _____ Zip _____ E-mail _____

Telephone # Home _____ Business _____

Occupation _____

What person or firm holds financial power of attorney? (Copy must be provided with application.)

Name _____ Telephone # _____

Emergency contact:

Name _____ Relationship to applicant _____

Address _____ City _____

County _____ State _____ Zip _____ E-mail _____

Telephone # Home _____ Business _____

Occupation _____

Medical power of attorney/durable power of attorney

Name _____ Relationship to applicant _____

Address _____

City _____ County _____ State _____ Zip _____

C. Hospitalization/medical facility stays (i.e. nursing home, rehabilitation, psychiatric, acute care, etc.) during the past year

<i>Name of hospital/facility</i>	<i>Dates</i>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

D. Applicant's physicians (Please list all, i.e. psychiatrist, oncologist, podiatrist, nurse practitioner, etc.)

<i>Physician Name</i>	<i>Specialty</i>	<i>Telephone #</i>	<i>Fax #</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

E. Special applicant-care needs

Grooms self: Yes___ No___ Dresses self: Yes___ No___ Bathes self: Yes___ No___

Special diet: Yes___ No___ (If yes, please specify) _____

Is the applicant bed-bound? Yes___ No___

Does the applicant use any special mobility equipment (i.e. wheelchair, cane, walker, etc.)?

Yes___ No___

If yes, what equipment will he/she bring with him/her? (Please specify) _____

Is the applicant continent? Yes___ No___

Does the applicant have a catheter? Yes___ No___

Does the applicant use oxygen? Yes___ No___

Does the applicant have hearing aids? Yes___ No___ Specify right/left and date of last exam _____

Does the applicant wear glasses? Yes___ No___ Date of last exam _____

Does the applicant wear dentures? Yes___ No___ Specify partial/full and date of last exam _____

Does the applicant see a podiatrist? Yes___ No___ Date of last exam _____

Does the applicant have any allergies (i.e. medication, food, latex, etc.)? Yes____ No____

If yes, please specify. _____

F. Applicant's mental status

Is the applicant alert? Yes____ No____

Is the applicant confused? Yes____ No____

Has the applicant ever been evaluated for memory loss? Yes____ No____

Is the applicant quiet and controlled? Yes____ No____

Is the applicant argumentative or combative? Yes____ No____

Is the applicant depressed or withdrawn? Yes____ No____

Does the applicant wander? Yes____ No____

Does the applicant have outbursts of temper? Yes____ No____

Does the applicant have episodes of crying, screaming, or yelling? Yes____ No____

Does the applicant generally get along well with others? Yes____ No____

Does the applicant enjoy conversation? Yes____ No____

Does the applicant enjoy activities? Yes____ No____

Does the applicant get dressed, groomed, and out of bed every day? Yes____ No____

If no, please explain. _____

State any other significant event or occurrence you recall about the applicant's mental condition. _____

Please note that each program requires individual supporting clinical documentation that you will be asked to supply prior to admission.

III. Insurance information

Does the applicant have traditional Medicare? Yes____ No____ Medicare # _____

Does the applicant have a Medicare HMO? Yes____ No____ HMO policy # _____

Name of Medicare HMO _____ Effective date of Medicare HMO _____

Does the applicant have a Medicare prescription plan? Yes____ No____

Name of Medicare prescription plan (i.e. formulary) _____

Does the applicant have PAAD or Senior Gold? Yes____ No____ PAAD/Senior Gold # _____

Does the applicant have any other insurance? Yes____ No____ If yes, please identify all insurances below.

Has the applicant applied for Medicaid or public assistance? Yes____ No____

If yes, Medicaid number _____ Effective date _____

Date of application _____ Caseworker's name _____

District application filed _____ Telephone number _____

Please check the type of insurance for each policy you/the applicant subscribe to.

HMO Prescription plan PPO Supplemental Long-term care insurance

Life insurance Other _____

1. Company _____ Telephone # _____

Address _____

Policy # _____ Group # _____

HMO Prescription plan PPO Supplemental Long-term care insurance

Life insurance Other _____

2. Company _____ Telephone # _____

Address _____

Policy # _____ Group # _____

HMO Prescription plan PPO Supplemental Long-term care insurance

Life insurance Other _____

3. Company _____ Telephone # _____

Address _____

Policy # _____ Group # _____

HMO Prescription plan PPO Supplemental Long-term care insurance

Life insurance Other _____

4. Company _____ Telephone # _____

Address _____

Policy # _____ Group # _____

HMO Prescription plan PPO Supplemental Long-term care insurance

Life insurance Other _____

5. Company _____ Telephone # _____

Address _____

Policy # _____ Group # _____

Has the applicant applied for Medicaid or public assistance? Yes____ No____

If yes, Medicaid number _____ Effective date _____

Date of application _____ Caseworker's name _____

District application filed _____ Telephone # _____

Please list all assets currently IN THE APPLICANT'S NAME that will be used to pay for care at the Center.

Monthly income	<u>Gross</u>	<u>Net</u>
Social Security		
Pension		
Veterans benefit		
Alimony		
Estates/trusts		
Rents		
Interest		
Dividends		
Salary		
Other income		
<i>Sub-total monthly income (net only)</i>		
Cash assets	<u>Date balance reflects</u>	<u>Balance in account</u>
Checking		
Savings		
CDs		
Securities (stocks and bonds)		
Life insurance cash value		
Other		
<i>Sub-total cash assets</i>		
Real estate		
Value of home		
Value of additional property		
<i>Sub-total real estate values</i>		
Debt		
Loans (home equity, personal, etc)		
Credit cards		
Mortgages		
Outstanding medical expenses		
Other		
<i>Sub-total debt</i>		()
Total available assets for use at CHCC		

IV. Financial information

Will the applicant pay for stay with his/her own funds? Yes____ No____

Does applicant own a home? Yes____ No____

If yes, specify location and lot/block number. _____

Please list spouse or children currently living in home:_____

Did the applicant own a home in the last 10 years? Yes____ No____

If yes, what was the disposition of the home? _____

Does the applicant own any other property? Yes____ No____

If yes, where is the property located? _____

Is the home or property currently for sale? Yes____ No____

If yes, will the proceeds be used to pay for the applicant's care? Yes____ No____

V. Certification

- According to the best of my knowledge, the information provided in sections I through IV is accurate and true in all respects.
- I understand no application is considered for admission until all requested information and supporting documentation is provided.
- I certify that all assets listed in section IV will be used for the care and treatment of the applicant. I understand that divestiture of funds, gifting, etc. of any reported assets may jeopardize future Medicaid eligibility and/or continued residence at CHCC.
- I agree, if admitted, to abide by the regulations and policies of CHCC.
- I agree, if admitted, to provide one month's security deposit equal to one month's room and board. I also agree to provide an advance payment equal to one month's room and board, payable upon admission.
- I agree, if admitted, to pay for a bed reserve (equal to the per diem room rate) for the day(s) between my formal commitment to accept a room at CHCC and the actual day of physical admission. The foregoing requirement for payment does not apply to a prospective applicant who has been determined at the time of admission to be eligible for Medicaid.

Signature of applicant

and/or

Signature of person acting for applicant

Date

Address

Telephone #

Relationship to applicant