



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. Resident's name _____ Male _____ Female _____

Home address _____ Telephone # _____

City _____ County _____ State _____ Zip _____

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

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

Please identify location:

Name _____ Telephone # _____

Address _____

Resident's birthplace* _____ Is the resident a US citizen? Yes _____ No _____

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

Primary language: English _____ other _____

Is the resident 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 resident have a living will/advance directive? Yes _____ No _____

(If yes, copies are required with application.)

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

Yes____ No____

Is the resident 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 resident _____

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 resident _____

Address _____ City _____

County _____ State _____ Zip _____ E-mail _____

Telephone # Home _____ Business _____

Occupation _____

Medical power of attorney/durable power of attorney

Name _____ Relationship to resident _____

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. Resident'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 resident-care needs

Grooms self: Yes____ No____ Dresses self: Yes____ No____ Bathes self: Yes____ No____

Special diet: Yes____ No____ (If yes, please specify) _____

Is the resident bed-bound? Yes____ No____

Does the resident 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 resident continent? Yes____ No____

Does the resident have a catheter? Yes____ No____

Does the resident use oxygen? Yes____ No____

Does the resident have hearing aids? Yes____ No____ Specify right/left and date of last exam _____

Does the resident wear glasses? Yes____ No____ Date of last exam _____

Does the resident wear dentures? Yes____ No____ Specify partial/full and date of last exam _____

Does the resident see a podiatrist? Yes____ No____ Date of last exam _____

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

If yes, please specify. _____

F. Resident's mental status

Is the resident alert? Yes____ No____

Is the resident confused? Yes____ No____

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

Is the resident quiet and controlled? Yes____ No____

Is the resident argumentative or combative? Yes____ No____

Is the resident depressed or withdrawn? Yes____ No____

Does the resident wander? Yes____ No____

Does the resident have outbursts of temper? Yes____ No____

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

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

Does the resident enjoy conversation? Yes____ No____

Does the resident enjoy activities? Yes____ No____

Does the resident 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 resident'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 resident have traditional Medicare? Yes____ No____ Medicare # _____

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

Name of Medicare HMO _____ Effective date of Medicare HMO _____

Does the resident have a Medicare prescription plan? Yes____ No____

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

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

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

Has the resident 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 resident 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 resident 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 RESIDENT'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 resident pay for stay with his/her own funds? Yes____ No____

Does resident own a home? Yes____ No____

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

Please list spouse or children currently living in home:_____

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

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

Does the resident 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 resident'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 resident. 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 resident 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