



Christian
Health Care
Center

301 Sicomac Avenue
Wyckoff, New Jersey 07481
(201) 848-5200 • www.chccnj.org

Application for Admission

Post-acute Care Unit

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 # _____

Marital status _____ Spouse's name _____

Room preference: Private _____ Semi _____

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.)

Is the resident currently a smoker? Yes _____ No _____

(CHCC is a smoke-free facility.)

Funeral/burial arrangements:

1. Name of funeral home: _____

Address _____ Telephone # _____

Name of cemetery _____

Address _____ Telephone #: _____

Does the resident have pre-paid funeral/burial arrangements? 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 _____

Telephone # Home _____ Business _____

Occupation _____

Medical power of attorney/durable power of attorney

Name _____ Relationship to resident _____

Address _____ City _____

County _____ State _____ Zip _____

Next of kin (not listed above):

1. Name _____ Relationship to resident _____

Address _____ City _____

County _____ State _____ Zip _____

Telephone # Home _____ Business _____

2. Name _____ Relationship to resident _____
 Address _____ City _____
 County _____ State _____ Zip _____
 Telephone # Home _____ Business _____

II. Physician and hospitalization information

A. 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>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

B. 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>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 # _____ Effective date _____

Date of application _____ Caseworker's name _____

District application filed _____ Telephone # _____

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 # _____

2. Company _____ Telephone # _____

Address _____

Policy # _____ Group # _____

3. Company _____ Telephone # _____

Address _____

Policy # _____ Group # _____

4. Company _____ Telephone # _____

Address _____

Policy # _____ Group # _____

5. Company _____ Telephone # _____

Address _____

Policy # _____ Group # _____

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____

