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

APPLICATION FOR ADMISSION

Please check appropriate box:
☐ Heritage Manor Nursing Home
☐ Southgate
☐ The Longview Assisted Living Residence
☐ Hillcrest Residence

Referred by: ________________________________

How did you hear about Christian Health Care Center?

___ Newspaper ad (Newspaper ________________)
___ Newspaper article (Newspaper ________________)
___ CHCC website
___ CHCC publication
___ Friend/word of mouth
___ Church bulletin (Church ________________)
___ Physician (Name ____________________)
___ Social worker (Name ________________)

I. General information regarding prospective resident

A. Applicant's name ____ Male____ Female___

Home address ____

Home telephone # __________________ Cell # _________________ Email: __________________

City ___________________________ County _______________ State_________ Zip_______________

Applicant's date of birth________________ Age _______ Social Security # _______________________

Marital status _______________________________ Spouse's name ___________________________

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

Please identify location: ____

Applicant's birthplace* __________________________ Is the applicant a US citizen? Yes____ No_____

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

Is the applicant a veteran? Yes____ No_____ Branch of service ___________________________________

Primary language: English _____ other ____

Is the applicant currently employed? _______________________________________Yes____ No_____

Education __________________________________ Past occupation___________________________

Religion_________ Church/town_________________________________Pastor __________________

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____

If applicant still drives and plans to bring a vehicle, please provide make of vehicle _________________
and license plate # ____________________________ .

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

B. **Financial guarantor (person to whom CHCC will send financial invoices)**

Name ______________________ Relationship to applicant ______________

Address ______________________ City ______________________

County ____________ State ________ Zip ________ Email ______________

Home telephone # ____________ Business # ____________ Cell # __________

Which of the above numbers is your primary contact number? ______________

Occupation ____

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

Name ________________________ Telephone # ________________

Emergency contact (Person CHCC will contact for emergencies and all issues related to care and treatment)

Name ______________________ Relationship to applicant ______________

Address ______________________ City ______________________

County ____________ State ________ Zip ________ Email ______________

Home telephone # ____________ Business # ____________ Cell # __________

Which of the above numbers is your primary contact number? ______________

Occupation ____

Medical power of attorney/durable power of attorney (copy required with application)

Name ____________________ Relationship to applicant ________________

Address ____

City ____________ County ______________ State ________ Zip ________

Mailings (person will receive all mailings and electronic communication from CHCC [excluding financial invoices], newsletters, invitations to events, etc.)

Name ______________________ Relationship to applicant ______________

Address ______________________ City ______________________

County ____________ State ________ Zip ________ Email ______________

Home telephone # ____________ Business # ____________ Cell # __________

Which of the above numbers is your primary contact number? ______________

Occupation ____

Next of kin (not listed above)

1. Name ______________________ Relationship to applicant ______________

   Address ______________________ City ______________________

   County ____________ State ________ Zip ________ Email ______________

   Home telephone # ____________ Business # ____________ Cell # __________

   Which of the above numbers is your primary contact number? ______________

   Occupation ____

2. Name ______________________ Relationship to applicant ______________

   Address ______________________ City ______________________

   County ____________ State ________ Zip ________ Email ______________

   Home telephone # ____________ Business # ____________ Cell # __________

   Which of the above numbers is your primary contact number? ______________

   Occupation ____

II. Medical Information

A. Current problem/diagnosis, including date of onset

____

____

____

____

B. Current medications (i.e. prescriptions, over-the-counter medications, vitamins, natural treatments, etc.)

____

____

____

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

Name of hospital/facility	*Dates*
______________________	________________
______________________	________________
______________________	________________

D. Advance directives

Does the applicant have written advance directives for life-sustaining treatment or Physician's Orders for Life Sustaining Treatment (POLST)? Yes____ No____

If yes, copies required with application.

A current do not resuscitate (DNR) order by a physician? ________________________Yes____ No____

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

Physician Name	*Specialty*	*Telephone #*	*Fax #*
________________	__________	____________	____________
________________	__________	____________	____________
________________	__________	____________	____________
________________	__________	____________	____________

F. Funeral/burial arrangements:

1. Name of funeral home: ______________________________________

   Address ______________________________ Telephone #________________

   Name of cemetery____

   Address ____

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

   If yes, which type of trust account were they placed in? ____ Revocable ____ Irrevocable

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

   Contact name ___________________________ Telephone #________________

G. 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 applicant independent with or without special mobility equipment? Yes____ No____

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. ____

H. 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 drug 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 on next page.

Is the applicant a Medicaid recipient? Yes____ No____

If yes, Medicaid # ____ Effective date___________________

If no, has the applicant applied for Medicaid or public assistance? Yes____ No____

If yes, county of application ___________________ Date of application ______________________________

Application Status ____________________________ Caseworker's name _____________________________

Caseworker's Telephone # _______________________

Please check the type of insurance for each policy you/the applicant subscribe to. Please provide copies (front and back) of all insurance cards.

☐ HMO ☐ Prescription plan ☐ PPO ☐ Supplemental ☐ Long-term care insurance ☐ Other ________

Company ____

Policy # __________________________ Group #_______________________

☐ HMO ☐ Prescription plan ☐ PPO ☐ Supplemental ☐ Long-term care insurance ☐ Other ________

Company ____

Policy # __________________________ Group #_______________________

☐ HMO ☐ Prescription plan ☐ PPO ☐ Supplemental ☐ Long-term care insurance ☐ Other ________

Company ____

Policy # __________________________ Group #_______________________

☐ HMO ☐ Prescription plan ☐ PPO ☐ Supplemental ☐ Long-term care insurance ☐ Other ________

Company ____Telephone #__________________

Policy # __________________________ Group #_______________________

☐ HMO ☐ Prescription plan ☐ PPO ☐ Supplemental ☐ Long-term care insurance ☐ Other ________

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

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

If yes, specify location and lot/block number.

Is the residence jointly owned? Yes____ No____

Please list spouse or children currently living in home:

Does the applicant have a disabled child who is currently receiving Social Security Disability Insurance benefits? Yes____No____

Did the applicant own a home in the last 15 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____

Have any assets been transferred in the last 60 months? Yes____ No____

If yes, please describe.

Have there been any gifts or loans for no consideration in the last 60 months? Yes____ No____

If yes, please list.

Have any trusts been established during the last 60 months? Yes____ No____

If yes, please describe.

Are there any pending lawsuits, settlements, accident claims, inheritance claims, or does anyone owe money to the applicant? Yes ___ No ___

If yes, please describe.

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 understand that a security deposit and advance payment will be required prior to the day of admission, based on the specific requirements of the program that the applicant is admitted to.
- 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

Christian Health Care Center respects all religious faiths and will not discriminate based upon race, religion, creed, national origin, sex, or age.