Valley View
REHABILITATION AND HEALTH CARE CENTER
1 Summit Avenue
Newton, NJ 07860
973-383-1450

APPLICATION FOR ADMISSION

Directions: Please complete this application in full for admission consideration. All information will be held in the strictest of confidence. Once completed, please return this application to the **Admissions and Billing Coordinator**. Please do not hesitate to contact us if you have any questions regarding this application. (Note: This application is not a binding agreement.)

General Information

Name _____
(As written on Medicare and/or Medicaid card)

Nickname, if any _____ Gender ____ Marital Status ____ Age ____

Date of Birth _____ Place of Birth _____ Citizen _____

Religion _____ SS# _____

Street Address _____

City, State, Zip Code_____

Currently at _____ Home _____ Hospital _____ Nursing Home _____ Other____

In order for our staff to provide optimal care, it is helpful for us to know selective personal information of the prospective resident. Please complete to the best of your ability.

Past Occupation _____ Former Educational Level _____

Primary Language: English ____ Yes ____ No Other: _____

Living Arrangement: ___Lived alone ___ w/family/support ___ other please specify____

List nursing home stay(s) within the last 3 months (facility name/dates):

_____

_____

List hospital stay(s) within the last 3 months (facility name/dates):

_____

_____

Indicate any behavior concerns exhibited by the applicant:
Anxious___ Uncooperative___ Combative___ Aggressive ___ Other___

Medical Information

Current Diagnosis, if known: _____

Height: _____ Weight: _____ recent weight change: ___Loss ___Gain

Impairments/Adaptive Equipment (check all that applies): ___ Speech ___ Hearing ___ Vision ___ Cane ___ Walker ___ Wheelchair ___ Brace ___ Pacemaker ___ other: _____

Has the applicant fallen in the last 6 months? ____No ____Yes, include date(s) and situation: _____

Has the applicant been evaluated by a Mental Health Specialist in the past 90 days?
___No ___Yes, include name(s), date(s), and reason(s):_____
_____

Has the applicant received psychotropic medications in the last several weeks?
___ No ___ Yes, include name(s), date(s), and reason(s) _____

Allergies/Reactions: _____

Hospital Preference: ____ Newton Memorial ____ Saint Clares-Sussex
____ Other: _____

1st Choice of Medical Doctor (See **Attending Physician List** in packet):
Physician's Name: _____
Address: _____
Telephone #: _____

2nd Choice of Medical Doctor (In event of 1st choice unavailability):
Physician's Name: _____
Address: _____
Telephone #: _____

Emergency Contact

Please list an individual who should be contacted in case of emergency:

Name: _____ Relationship: _____
Address: _____ City, State, Zip Code: _____
Home Phone: _____ Cell Phone: _____
Email Address: _____

Individual Responsible For Account Payment

Name: _____ Relationship to Resident: _____

Street address: _____

City: _____ State/Zip: _____

Home Telephone: _____ Work Telephone: _____

Medical Insurance Information

Medicare#: _____ Effective Date: _____ __Part A __Part B
Medicare Supplement: _____Group# _____ Policy# _____
Long-term care insurance: _____Group# _____ Policy# _____
Other insurance: _____Group# _____ Policy# _____

Medicaid Information

Has the Resident applied, or will the Resident be applying, for Medicaid? _____
If the Resident has applied: Date: _____ County: _____

Local County Agency Contact Name: _____
Telephone: _____

Please bring all Insurance Cards, Advance Directive, Power of Attorney (POA), and most recent bank statement(s) along with application submission

Clergy

Name: _____ Phone: _____

Address: _____

Church: _____

Would you like us to notify the clergy person upon admission? __Yes __No

Have prepaid funeral arrangements been made? ___Yes ___ No
Funeral Home: _____Telephone: _____
Address: _____

Financial Information

Must be completed by each individual; joint holdings must be so noted.

ASSETS	**AMOUNT**	**Is the asset security for a loan?**	
		Yes	**No**
Cash (Savings & Checking)	$		
CD's, Money Markets, etc.	$		
Stock & Bonds	$		
IRA's, Annuities, etc.	$		
House	$		
Other Real Estate	$		
Trust Fund (indicate % beneficial int.)	$		
Cash Surrender Value of Life Insurance	$		
Other Assets (Describe Below): _____ _____ _____	$		
TOTAL ASSETS	$	XXX	XXX

LIABILITIES	**AMOUNT**
Mortgage on Residence	$
Mortgage(s) on Other Real Estate	$
Other Bank Loans	$
Loans Against Cash	$
Medical Insurance Premiums	$
Other Liabilities (Notes Payable, etc.)	$
TOTAL LIABILITIES	$

Has the prospective resident guaranteed any debt owed by another? ____No ____Yes

Guarantor(s)	**Debtor**	**Relation**	**Amt of debt guaranteed**
			$
			$

MONTHLY INCOME	**AMOUNT**
Social Security	$
Pension	$
Dividends	$
Interest	$
Mortgage/Rental Income	$
IRA Income	$
Trust Income	$
Other Monthly Income	$
TOTAL MONTHLY INCOME	$

Referred to Valley View Rehabilitation & Healthcare Center by:

_____

In order to expedite the admission process, please contact the Social Worker at present facility, if applicable, and request them to **fax** the current face sheet, nursing notes, history/physical, and discharge plan/date to Valley View Rehabilitation & Healthcare Center (973) 383-9338, **Attention: Admission Coordinator.**

I hereby certify that the information contained in this application for admission is accurate, complete and not misleading. If accepted, I agree to comply with the rules and regulations of Valley View Rehabilitation & Healthcare Center. I understand that completion of this document does not imply acceptance into the facility.

_____ _____

Applicant's Signature **Date**

_____ _____

Resident Representative Signature **Date**

****

FOR OFFICE USE ONLY:

_____ Approved _____Denied

Reason for Denial

_____

_____

Added to waiting list_____ Admission date scheduled_____

Admission Coordinator _____ _____
Date

Director of Nursing _____ _____
Date

Administrator _____ _____
Date

Executive Director _____ _____
Date