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	$

Has there been any gifting in the past 5 years? ______________________________

____

Referred to Valley View Rehabilitation & Health Care 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 & Health Care 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 & Health Care 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