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.

Name of hospital/facility	*Dates*

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

Physician Name	*Specialty*	*Telephone #*	*Fax #*

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____

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 Christian Health Care Center.
- I agree, if admitted, to abide by the regulations and policies of Center.
- 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 the Center 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.
- The Center respects all religious faiths and will not discriminate based upon race, religion, creed, national origin, sex or age.

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Signature of applicant and/or Signature of person acting for applicant

______________________ Date

______________________ Address

______________________ Telephone #

______________________ Relationship to applicant

Date received completed application: ______________________________
CHCC use only