

# **THE ELMS OF CRANBURY**

**APPLICATION FOR ADMISSION**

*Personal and Confidential*

# APPLICATION FOR ADMISSION

All applicants for admission to The Elms of Cranbury must complete the following questionnaire, sign it and return it to the admissions office. This application will become part of the applicants record and should be completed in its entirety. All information will be kept strictly confidential.

Date: \_\_\_\_\_

## I. General Information

Name of Prospective Resident: \_\_\_\_\_ Telephone No: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

Race: \_\_\_\_\_ Religious Denomination: \_\_\_\_\_ Church: \_\_\_\_\_

Primary Language: \_\_\_\_\_ Lifetime Occupation: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Maiden Name: \_\_\_\_\_

Military Service: \_\_\_\_\_

Personal Physician's Name: \_\_\_\_\_ Telephone No: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

Will he/she attend here? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Individual Making Inquiry: \_\_\_\_\_ Telephone No: ( ) \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State/Zip: \_\_\_\_\_

Is the prospective resident aware of the placement decision? Yes \_\_\_\_\_ No \_\_\_\_\_

### How did you hear about us?

Newspaper \_\_\_\_\_ Yellow Pages \_\_\_\_\_ Personal Referral \_\_\_\_\_ Hospital \_\_\_\_\_

Physician \_\_\_\_\_ Other Nursing/AL Facility \_\_\_\_\_ Brochure \_\_\_\_\_ Other \_\_\_\_\_

Desired Admission Date: \_\_\_\_\_ Current Location of Prospective Resident: \_\_\_\_\_

Reason for seeking admission: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

Current Physical Condition: \_\_\_\_\_

## II. Responsible Parties

### Who will be responsible for paying the bills?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State/zip: \_\_\_\_\_

Telephone No. (home): ( ) \_\_\_\_\_ Telephone No. (work): ( ) \_\_\_\_\_

Has anyone been appointed Power of Attorney or Guardian? Yes \_\_\_\_\_ No \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ County: \_\_\_\_\_ State/zip: \_\_\_\_\_

Telephone No. (home): ( ) \_\_\_\_\_ Telephone No. (work): ( ) \_\_\_\_\_

Does the Prospective Resident have an Advanced Directive or Living Will? Yes \_\_\_\_\_ No \_\_\_\_\_

Additional Persons to contact in case of emergency:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ State/Zip: \_\_\_\_\_  
Telephone No. (home): ( ) \_\_\_\_\_ Telephone No. (work): ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ State/Zip: \_\_\_\_\_  
Telephone No. (home): ( ) \_\_\_\_\_ Telephone No. (work): ( ) \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ County: \_\_\_\_\_ State/Zip: \_\_\_\_\_  
Telephone No. (home): ( ) \_\_\_\_\_ Telephone No. (work): ( ) \_\_\_\_\_

**III. Financial Information**

Medicare #: \_\_\_\_\_ Effective Date: \_\_\_\_\_ Part A: \_\_\_\_\_ Part B: \_\_\_\_\_  
Primary Insurance Co. Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Secondary Insurance Co. Name: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Prescription Card: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Other Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_

Monthly Income of Prospective Resident:

Salary:	\$	_____
Social Security:		_____
Pensions/Annuities:		_____
IRA		_____
Interest/Dividend Income		_____
Rental Income		_____
Investments/Trusts/Other		_____
Veterans Benefits		_____
Alimony		_____
Other (please specify) _____		_____
Total Monthly Income	\$	_____

Assets:

Cash:

Institution: _____	
Type of Account: _____	
Account #: _____	
Balance:	\$ _____
Institution: _____	
Type of Account: _____	
Account #: _____	
Balance:	\$ _____
Institution: _____	
Type of Account: _____	
Account #: _____	
Balance:	\$ _____

Securities (stocks/bonds):

Company: \_\_\_\_\_  
Approximate Value: \$ \_\_\_\_\_  
Company: \_\_\_\_\_  
Approximate Value: \$ \_\_\_\_\_

Real Estate:

Address: \_\_\_\_\_  
Is anyone currently living here? Yes \_\_\_\_\_ No \_\_\_\_\_  
Is the property owned jointly? Yes \_\_\_\_\_ No \_\_\_\_\_  
Name of co-owner: \_\_\_\_\_  
Approximate Value: \$ \_\_\_\_\_  
Additional Property: \$ \_\_\_\_\_

Other Assets:

Cash value of Life Insurance: \$ \_\_\_\_\_  
Vested Pension Benefits: \$ \_\_\_\_\_  
Business Interests: \$ \_\_\_\_\_  
Automobiles: \$ \_\_\_\_\_  
Other: \$ \_\_\_\_\_  
  
Total Assets: \$ \_\_\_\_\_

Liabilities:

Mortgage: \$ \_\_\_\_\_  
Credit Cards: \$ \_\_\_\_\_  
Loans: \$ \_\_\_\_\_  
Other Debt \_\_\_\_\_: \$ \_\_\_\_\_  
Taxes/Liens: \$ \_\_\_\_\_  
  
Total Liabilities: \$ \_\_\_\_\_  
  
Net Worth (Assets - Liabilities): \$ \_\_\_\_\_

Medicaid/Title IXI

Has the potential resident applied (or will be applying shortly) for Medical Assistance?

Yes \_\_\_\_\_ No \_\_\_\_\_ Medicaid #: \_\_\_\_\_

If an application was made, what was the date? \_\_\_\_\_ County: \_\_\_\_\_

Case Worker Name: \_\_\_\_\_ Telephone No. ( ) \_\_\_\_\_

I hereby certify that to the best of my knowledge, the information provided is accurate, true and complete. I understand the The Elms of Cranbury will rely upon the accuracy and completeness of the above information to make an admission decision, and that if any information has been falsely represented, this will be sufficient cause for denying application for admission.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

The Elms of Cranbury complies with the provisions of Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973 and the Age Discrimination Act of 1975. No individual shall be denied provision of services on the basis of race, creed, color, national origin, disability, age, sex, marital or veteran status.

