Jewish Home at Rockleigh

RUSS BERRIE HOME FOR JEWISH LIVING

APPLICATION FOR ADMISSION

Please complete all of the information requested in this application. You may type directly into this application or print it out and complete it by hand. Send your completed application to Carol Lippert, Director of Admissions:

By Mail:
Carol Lippert
Director of Admissions
Jewish Home at Rockleigh
10 Link Drive
Rockleigh, NJ 07647

By Fax:
(201) 784-6906
Attn: Carol Lippert

Jewish Home at Rockleigh
RUSS BERRIE HOME FOR JEWISH LIVING

DATE

APPLICATION FOR ADMISSION

I. GENERAL INFORMATION

Applicant's Name Age

Date of Birth Place of Birth

Social Security No. Medicare No.

Medicaid No. PAA/Drug Card

Supplemental Insurance Policy No.

Home Address

City County State Zip

Applicant is now at: ☐ Home ☐ Hospital ☐ Nursing Home ☐ Assisted Living ☐ Other

Please identify location:

Name of Facility

Address

Telephone Length of Stay

☐ Own Home ☐ Rent ☐ Living Arrangements (alone or with others; please specify name, age and relationship to Applicant)

Primary Language: ☐ English ☐ Other, please specify

Is Applicant US citizen? ☐ Yes ☐ No; explain citizenship status

Date of entry into US

Marital Status: ☐ Married ☐ Divorced ☐ Widowed; Date of Spouse's death

Name of Spouse

Did you serve in Armed Forces? ☐ No ☐ Yes; Branch of Service

Dates of Service

Religion: ☐ Jewish ☐ Catholic ☐ Protestant ☐ Other

Place of Worship

Clergy Telephone

Copies of the following documents, if applicable, must be submitted with this application:

1. **Applicant's Birth Certificate or Naturalization Papers or Legal Alien Card**
2. **Social Security Card and Award Letter computer printout**
3. **Medicare Card and Supplemental Insurance Card**
4. **Medicaid Card and Medicaid Approval Letter**

- Does Applicant have a Will? ☐No ☐ Yes; Date of Will

Name and address of Executor

- Does Applicant have Advance Directive or Health Care Proxy? ☐No ☐ Yes (submit copy)

Name of Proxy Relationship

Address

Home Telephone Business

- Does Applicant have Financial Power of Attorney? ? ☐No ☐ Yes (This person must sign Admission Agreement and complete Addendum thereto) (Submit copy of POA)

Name of POA Relationship

Address

Home Telephone Business

- Does Applicant have Legal Guardian? ☐No ☐ Yes (submit copy of Guardianship Papers)

Name of Guardian Relationship

Address

Home Telephone Business

RESPONSIBLE PARTY AND OTHER PARTIES TO BE NOTIFIED IN CASE OF ILLNESS, INCIDENT, OR EMERGENCY:

1. Name Relationship

   Address

   City State Zip

   Home Phone Business

2. Name Relationship

   Address

   City State Zip

   Home Phone Business

3. Name Relationship

   Address

   City State Zip

   Home Phone Business

- Does Applicant have children? ☐No ☐Yes

1. Name Relationship
   Address
   City State Zip
   Home Phone Business

2. Name Relationship
   Address
   City State Zip
   Home Phone Business

3. Name Relationship
   Address
   City State Zip
   Home Phone Business

- Does Applicant have Funeral/Burial Arrangement? ☐No ☐Yes

Name of Funeral Home
Contact Telephone
Address
Name of Cemetery
Address
Telephone Plot No.

Attach copy of burial contract and/or plot information

II. FINANCIAL REPRESENTATIVE/RESPONSIBLE PARTY

Name Relationship
Address
City State Zip
Home Phone Business
Fascimile Email

- Will Responsible Party use Applicant's assets, as described below in Section III, to pay for Applicant's care? ☐ No ☐ Yes (attach copy of Power of Attorney)
  If no, identify the funds or assets to be used to pay for applicant's care

III. MEDICAL INFORMATION

Current diagnosis/problem

How long has this problem/condition existed?

Other medical problems

Current medications

- Last hospitalization: Hospital
  Reason Dates from to
- Has Applicant ever been hospitalized for psychiatric diagnosis? ☐ No ☐ Yes; explain
  Dates
- Nursing Home or Rehab stay: ☐ No ☐ Yes ; Dates
  Why did applicant leave?
- Current Physician
  Address Telephone
  Specialists
  Address Telephone
- Current Dentist
  Address Telephone
- Is Applicant currently under care of psychiatrist? ☐ No ☐ Yes
  Psychiatrist
  Address Telephone

IV. APPLICANT'S CARE NEEDS (Activities of Daily Living)

- Grooms Self: ☐ No ☐ Yes
- Bathes Self: ☐ No ☐ Yes
- Dresses Self: ☐ No ☐ Yes
- Feeds Self: ☐ No ☐ Yes

- Physical Mobility: ☐ Walks unassisted ☐ Bed bound
  ☐ Needs assistance ☐ Cane ☐ Walker
  ☐ Wheelchair ☐ Propels self with wheelchair

- Is Applicant incontinent: ☐ No ☐ Yes ☐ Bladder ☐ Bowel ☐ Both
- Does Applicant need assistance with toileting? ☐ No ☐ Yes
- Does Applicant need catheter? ☐ No ☐ Yes; explain
- Does Applicant require Oxygen? ☐ No ☐ Yes
- Does Applicant wear glasses? ☐ No ☐ Yes
  Date of last eye exam
- Does Applicant wear dentures? ☐ No ☐ Yes
  Date of last dental/gum exam
- Does Applicant have any physical deformities that require special care? ☐ No ☐ Yes
  Explain

V. APPLICANT'S MENTAL STATUS

- Is Applicant alert? ☐ No ☐ Yes ☐ Is Applicant confused? ☐ No ☐ Yes
- Does Applicant exhibit the following symptoms/behavior?
  ☐ Depressed ☐ Withdrawn ☐ Outbursts of temper ☐ Episodes of crying
  ☐ Combativeness ☐ Loud outbursts, yelling ☐ Wandering
- Is Applicant social / get along well with others? ☐ No ☐ Yes
- Does Applicant engage in conversation? ☐ No ☐ Yes
  Does Applicant enjoy participating in activities? ☐ No ☐ Yes; list activities

State other significant events/behavior or occurrences regarding the Applicant's mental condition that would impact on the facility's ability to care for Applicant

All applications for those individuals currently hospitalized or living in another facility must include a preliminary transfer sheet, including recent medical consultations. For those applying from home or community, this applications must include current medical information and applicant's history from his/her personal physician.

VI. FINANCIAL INFORMATION

Current Income / Benefits

	MONTHLY **$**	**ANNUALLY** **$**	**RECIPIENT AND NAME OF COMPANY/SOURCE WITH INFORMATION**
Social Security			
Pension Government Private			
Annuity (ies)			
Interest			
Reparations			
Veteran's Benefits			
Railroad Retirement			
SSI (Supplemental Soc. Security)			
Fed. Civil Service Annuity			
Unemployment Compensation (UIB)			
Worker's Compensation			
Sick or Disability Payments			
Strike Benefits			
Military Allotments			
Payment from Boarders			
Public Assistance			
Black Lung Benefits			
Dividends, Royalities, etc.			
Estates/Trusts			
Rents			
Other Income (inheritance, alimony, gifts, winnings)			
TOTAL INCOME	$ 0.00	$ 0.00	

In order to process this application, please attach copy (ies) of most recent account statements for the items listed below:

Assets

	Name of Bank/Institution Address and Telephone Ownership Account Number	**Total value $**
Cash on hand		
Checking Account		
Savings Accounts (Money Market, Certificates of Deposit, etc.)		
US Savings Bonds Stocks, Securities		
Trust Fund		
IRA, Keogh or other Tax deferred income		
Notes/Contracts of Value		
Tangible Personal Property (Antiques, objects d'art – identify and state value)		
Credit Union Membership		
Mutual Funds		
Vehicles		
Other		
TOTAL ASSETS		**$ 0.00**

- Does the Applicant have a personal Broker/Agent? ☐ No ☐ Yes
  Name Telephone
  Address
- Does Applicant have any pending claims, such as: lawsuits, divorce settlements, inheritance, accident claims, sale of property or other claims, or does anyone owe Applicant money? ☐ No ☐ Yes; Explain
  Name of Attorney Telephone

REAL ESTATE

- I own the following real estate, situated in the town/city of
  County State
  Description of property (i.e. residential, land, etc.)
  Estimated market value:
  Property is owned by
  Mortgage held by: Bank
  Address
  Type of Mortgage Amount
- I own the following real estate, situated in the town/city of
  County State
  Description of property (i.e. residential, land, etc.)
  Estimated market value:
  Property is owned by
  Mortgage held by: Bank
  Address
  Type of Mortgage Amount
  Additional properties/information:

Please attach copies of deeds for the above properties in order to process this application.

INSURANCE

- Do you have Life Insurance: ☐ Yes ☐ No

  Insurance Company

  Policy No.

  Face Value Cash Value

  Name of Policy Holder

  Name of Insured

  Name of beneficiary(ies) and relationship to insured:

  Contingent beneficiary(ies) and relationship to insured

- Is applicant named as beneficiary on another's insurance policy? ☐ Yes ☐ No
  If yes, Name and relationship to Applicant
- Do you have Long Term Care Insurance: ☐ Yes ☐ No
  Insurance Company

  Policy No.

  Name of Insured

In order to process this application, attach copies of insurance policies.

MEDICAL INSURANCE

- Primary Insurance Company

  Address Tel.

  Name of Policyholder for Applicant

  Type of coverage

  Policy Number Group
- Secondary/Supplemental Insurance

  Address Tel

  Name of Policyholder for Applicant

  Type of coverage

  Policy Number Group

In order to process this application, attach copies of insurance cards and most recent bill.

LIABILITIES (as of application date)

	Description	Amount $	Payable to: bank, individual, etc.
Notes			
Loans			
Mortgages			
Outstanding bills			
Other			
Total Liabilities		**$ 0.00**	

VII. PAYMENT INFORMATION

- Will Applicant pay for stay with his/her own funds? ☐ Yes ☐ No
- Has Applicant applied for Medicaid (New Jersey) or Public Assistance? ☐ Yes ☐ No
  If yes, provide Medicaid No. and copy of Medicaid Approval Letter. Date of Medicaid application
  Caseworker Name
  County Telephone
  Has applicant received medical approval from Medicaid? ☐ Yes ☐ No
  Date PAS #
- Was Applicant denied for Medicaid or Public Assistance? ☐ Yes ☐ No
  If yes, attach copy of denial letter.
- Has Applicant applied for Medicaid in another state? ☐ Yes ☐ No; State

VIII. MISCELLANEOUS INFORMATION

- Is Applicant aware of this application and agreeable to placement? ☐ Yes ☐ No
- Can he/she be contacted regarding status of this application? ☐ Yes ☐ No
- Please check the appropriate answer:
  ☐ I am ready for immediate placement when a bed becomes available.
  ☐ I am not ready for immediate placement when a bed becomes available.

CERTIFICATION

I understand no application is considered for admission until all requested information is furnished. I agree, if admitted, to abide by the rules, regulations and policies of the Jewish Home at Rockleigh.

I represent that to the best of my knowledge, the above statements and information provided are true and correct.

_____ _____

Witness Signature of Applicant

_____

Print Name

_____

Date

_____ _____

Witness Signature of Representative

_____

Print Name

_____

Date