



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 our admissions department:

By email: admissions@jewishhomerockleigh.org

By Mail:

Jewish Home at Rockleigh
Admissions Department
10 Link Drive
Rockleigh, NJ 07647

By Fax:

(201) 256-4100
Attn: Admissions

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 Boards			
Public Assistance			
Black Lung Benefits			
Dividends, Royalties, 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

- | | |
|--|-------|
| <ul style="list-style-type: none"> Primary Insurance Company | |
| Address | Tel. |
| Name of Policyholder for Applicant | |
| Type of coverage | |
| Policy Number | Group |
| <ul style="list-style-type: none"> 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