ROSE GARDEN NURSING & REHABILITATION CENTER
1579 OLD FREEHOLD ROAD
TOMS RIVER, N.J. 08755

APPLICATION FOR ADMISSION

Date: _____

Applicant's Name _____ Home Phone: _____

Address: _____

DOB: _____ Sex: _____ Religion: _____ Marital Status: _____

SS #: _____ Advanced Directive: Yes ( ) No ( )
Insurance: * Copies of insurance cards should accompany this application
Medicare # _____ Part A ( ) Part B ( )

Medicare HMO _____ Policy # _____

Supplemental Ins. _____ Policy # _____

Other Ins. _____ Policy # _____

Other Ins. _____ Policy # _____

Has applicant ever been in another nursing center? Yes ( ) No ( )
If yes, please list the nursing center and dates of stay _____

Contact Information

Responsible Party Name: _____ Relationship: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell: _____

Other Persons To Contact In Case Of Emergency

Name	Relationship	Address	Phone

If discharge status changes and applicant's stay is extended, I agree to provide any and all supplemental information as outlined on the following pages in this application.

Signature of applicant or responsible party:

_____ Date: _____

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MEDICAL & PERSONAL DATA

Primary Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

Other Physician: _____ Phone: _____

Is the applicant aware of the placement decision? Yes ( ) No ( )

Has the applicant made pre-paid funeral arrangement? Yes ( ) No ( )

Funeral home preference: _____ Phone: _____

FINANCIAL INFORMATION

To process your application, the following information is needed. The information supplied is strictly confidential and allows us to assist you in the financial planning for your care. The financial data should be that of the applicant. Your cooperation is appreciated in order to expedite admission.

The name (s) of the person (s) who will be responsible for facilitating payment:

Name (Please Print)	Address	Home/Office Phone	Relationship

The person (s) name (s) that are listed must also sign this section:

Signature (s) _____

Does the applicant have any of the following?

Trust account _____ Yes ( ) No ( )

Legal Guardian _____ Yes ( ) No ( )

Power of Attorney _____ Yes ( ) No ( )

If yes, DOCUMENTATION of Trust, Guardianship or Power of Attorney will be required.

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MONTHLY INCOME:	**AMOUNT:**
Salary	$ _____
Social Security	$ _____
Pensions/Annuities	$ _____
IRA	$ _____
Interest/Dividend Income	$ _____
Veteran's Benefits	$ _____
Alimony	$ _____

TOTAL MONTHLY INCOME

Assets	Bank Name/Location	Account No.	BALANCE
Cash	_____	_____	$_____
Checking	_____	_____	$_____
Savings	_____	_____	$_____
Other Securities (Stocks/Bonds)	_____	_____	$_____

Real Estate (Description/Location)

Address City State

_____ $_____

_____ $_____

Jointly Owned? Yes ( ) No ( ) Name of Co-Owner _____

Is anyone currently living in this home? Yes ( ) No ( )

If yes, Name: _____ Relationship: _____

Other Assets:

1. Cash Value of Life Insurance $_____

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2. Vested Pension Benefits $_____

3. Business Interests $_____

4. Automobiles $_____

5. Funeral Account (If not irrevocable trust) $_____

6. Other $_____

TOTAL ASSETS (A) $_____

LIABILITIES

Home Mortgage $_____

Credit Cards/Charge Accounts $_____

Loans $_____

Other Personal Debts: _____ $_____

Medical Expenses $_____

Tax Owed/Liens $_____

TOTAL LIABILITIES (B) $_____

NETWORTH (Subtract Line B From Line A) (C) $_____

*Please provide the appropriate statements/ documentation to support the above financial data.

Does the applicant currently receive Medicaid benefits in the community?
Yes ( ) No ( ) If Yes, Medicaid # _____

Has an application for Medicaid Long Term Care Benefits been initiated?
Yes ( ) No ( ) If Yes, Case Workers' Name _____

Has an application for Medicaid Long Term Care Benefits been approved or denied?

Approved _____ Date _____ Medicaid # _____

Denied _____ Date _____ Reason _____

I hereby certify to the best of my knowledge and belief, the above stated information is true, correct and complete. I understand that Rose Garden will rely upon the accuracy and completeness of the above financial information in making an admission decision, and if any information has been falsely represented, this will be sufficient cause for voiding my application for admission.

In addition, I understand that Rose Garden will rely upon the accuracy and completeness of the above financial application to determine the applicant's responsibility for private payments or eligibility for benefits under government or commercial insurance programs.

I understand that I must notify Rose Garden in writing of any substantial change in financial condition. All of the information will be kept confidential.

Signature of Applicant and/or Responsible Party.

Signature: _____ Date: _____

Signature of Nursing Care Representative

Signature: _____ Date: _____

Doctor,
Please include complete instructions with start and finish date for all prescriptions.

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Pre-Admission Medical Exam form

Patient Name _____

Address _____

Physician completing form _____

1. Diagnosis _____

_____

A. Working _____

_____

B. Final _____

_____

C. Complications _____

_____

2. Personal History _____

_____

_____

3. Present Illness (onset & history) _____

_____

_____

4. Subjective Symptoms _____

_____

_____

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5. Pertinent Physical Findings _____

_____

Lab/X-Ray Results _____

6. Prognosis _____

_____

7. Allergies _____

_____

8. Medications/Treatments _____

_____

_____

Present Diet _____

9. Flue Shot _____ Pneumonia Vaccination _____

Chest X-Ray _____

Height _____ Weight _____

Adaptive Devices _____

_____
Physicians Signature

_____
Office Number

_____
Date

Please include copies of any recent Lab results or Chest X-Rays.