MEADOWVIEW NURSING HOME
235 Dolphin Avenue
Northfield, New Jersey 08225

APPLICATION FOR ADMISSION

APPLICANT NAME _____
LAST FIRST MI

HOME ADDRESS _____
STREET/APT. NO.

_____
CITY STATE ZIP CODE

COUNTY OF RESIDENCE _____

SEX ____ M _____ F DATE OF BIRTH _____ BIRTH PLACE_____
MO/DAY/YEAR

MARITAL STATUS ( ) SINGLE, NEVER MARRIED ( ) MARRIED ( ) SEPARATED ( ) DIVORCED ( ) WIDOWED

NAME OF SPOUSE _____

RELIGION _____ OCCUPATION BEFORE RETIREMENT _____

HISTORY OF SMOKING _____ YES _____ NO

PRIMARY LANGUAGE _____

SOCIAL SECURITY NO. _____ MEDICARE NO. _____
(PLEASE PROVIDE COPY) (PLEASE PROVIDE COPY)

MEDICAID NO. _____ PROGRAM (i.e., CCPED, etc.)_____
(PLEASE PROVIDE COPY)

HAS AN APPLICATION BEEN SUBMITTED FOR MEDICAID? _____ YES _____ NO

IF YES, WHEN _____ IN WHAT COUNTY? _____

NAME OF CASEWORKER _____

VETERAN STATUS _____ BRANCH _____

ADDITIONAL HEALTH INSURANCE _____ YES _____ NO

IF YES, COMPANY NAME _____

ADDRESS _____

_____

ID NUMBER _____
(PLEASE PROVIDE A COPY OF THE CARD AND THEBILL)

CURRENT LIVING ARRANGEMENTS _____ HOME HOSPITAL _____
(NAME)

NURSING HOME _____ ASSISTED LIVING FACILITY _____
(NAME) (NAME)

MEDICAL DIAGNOSIS/NEED FOR NURSING HOME CARE (Give brief description):

_____

_____

NAME OF PHYSICIAN(S) CURRENTLY PROVIDING YOUR CARE: _____

_____

HOSPITAL PREFERENCE:

_____ SHORE MEMORIAL _____ ACMC - MAINLAND

_____ ACMC - CITY OTHER (SPECIFY) _____

FUNERAL HOME _____ TEL. NO. _____

ADDRESS _____

_____

DOES APPLICANT HAVE A POWER OF ATTORNEY? _____ YES _____ NO

DOES APPLICANT HAVE AN ADVANCE DIRECTIVE/LIVING WILL? ____YES ____NO

INCOME:

SOCIAL SECURITY _____ YES _____ NO MONTHLY AMOUNT _____

PENSION _____ YES _____ NO MONTHLY AMOUNT _____

OTHER INCOME* _____YES _____ NO MONTHLY AMOUNT _____

* IF YES TO OTHER INCOME, IDENTIFY SOURCE: _____
(PLEASE PROVIDE VERIFICATION OF INCOME(S))

RESOURCES, PLEASE LIST VALUE:

( ) CASH ON HAND _____
( ) SAVINGS AND/OR CHECKING ACCT. _____
( ) CERTIFICATES OF DEPOSIT _____
( ) STOCKS/BONDS/INVESTMENTS _____
( ) OWNERSHIP OF ANY REAL PROPERTY _____

PLEASE PROVIDE VERIFICATIONS OF ALL ACCOUNTS (I.E., BANK STATEMENTS, ACCOUNT STATEMENTS, DEED., MORTGAGES HELD, ETC.)

PRIMARY PERSON TO BE CONTACTED IN AN EMERGENCY:

NAME _____ RELATIONSHIP _____

ADDRESS _____

TEL. (H) _____ (W) _____ (C) _____

E-MAIL ADDRESS _____

SECONDARY CONTACT PERSON(S):

1) NAME _____ RELATIONSHIP _____

ADDRESS _____

TEL. (H) _____ (W) _____ (C) _____

E-MAIL ADDRESS _____

2) NAME _____ RELATIONSHIP _____

ADDRESS _____

TELL. (H) _____ (W) _____ (C) _____

E-MAIL ADDRESS _____

IF ANY INFORMATION THAT IS LISTED ON THE APPLICATION SHOULD CHANGE OR IF WE CAN HELP WITH ANY QUESTIONS YOU MAY HAVE, PLEASE CONTACT

THE ADMISSIONS OFFICE AT (609) 645-5955, EXTENSION 4556, MONDAY THROUGH FRIDAY, 8:30 AM TO 5:00 PM.

By signing this application I hereby authorize Meadowview Nursing Home to request medical information concerning the person applying for admission.

_____ _____

SIGNATURE OF APPLICANT OR REPRESENTATIVE DATE

PLEASE RETURN COMPLETED APPLICATION TO:

MEADOWVIEW NURSING HOME
ADMISSIONS OFFICE
235 DOLPHIN AVENUE
NORTHFIELD, NJ 08225

FOR OFFICE USE ONLY

BY _____ _____

DATE RECVED BY MEADOWVIEW NRSG HOME

Application for Admission - online application-jkd 06/09