# ROCKVILLE NURSING HOME – ADMISSION APPLICATION

**303 Adclare Road Rockville, Maryland 20850**
**Phone 301.279.9000 Fax Application to 301.279.5885**

**Date of Application** ________________ **Estimated Length of Stay** _____________

**Applicant Name** ____________________________________ **Birth Date** ____________
**Last First MI**

Current Medical Problem(s) ________________________________________________________

Referred By_________________________ Discharge Plan, If Rehab Stay__________________

Past Medical Problem(s) ___________________________________________________________

**Current Insurance Information**

Medicare # ___________________ Part A Yes/No Social Security # ___________________

Other Insurance: ____________________________ Policy # _________________________
Name of Insurance Company

**Expected Pay Source - Please check one below**

_____Private

_____Medicare – Part A (if requirements are met)
First 20 Days-No Charge
Days 21-100 $128.00 Co-Payment

_____Medicaid- already in place (State)

_____Medicaid – in process of applying

**Applicant Resources [Approximate Assets] To be used in the payment of various co-insurances**

Income: Include social security, dividends, retirement, etc. – Monthly total $ __________

Bank Accounts: Checking: $__________________ Savings: $_______________

Approximate Value: Stocks/Bonds: $________________ Property: $_______________

Are any of the above funds held jointly? Yes _________ No __________

Are these funds intended /available for use to pay for resident stay? Yes____ No ______

In the past 5 years has the applicant held any assets which were transferred, given away or gifted to anyone?
Yes ______________ No _______________

***Note – Facility will complete forms for reimbursement to patient for 3rd party insurance.**

**Billing Contact** **Relationship** __________

**Name** ________________________________

**Address**______________________________

**City, State, Zip**________________________

**Home Phone** __________________________

**Work Phone** __________________________

**Cell Phone:** ____________________________

**Health Care Decision Maker/Contact** **Relationship**_________

**Name** ________________________________

**Address**______________________________

**City, State, Zip**________________________

**Home Phone** __________________________

**Work Phone** __________________________

**Cell Phone:** ____________________________