# ROCKVILLE NURSING HOME
## STEPPE MEMORIAL BUILDING

## APPLICATION FOR ADMISSION

**Applicant's Name: _____ Application Date ____/_____/____**
**First M Last Mo Day Year**

**How did you hear about Rockville Nursing Home? _____**

**I. GENERAL INFORMATION**

**Applicant's Date of Birth: _____ Age: _____ Social Security Number: _____**

**Applicant's Current Location: _____**

**Most Recent Address: _____**

**Marital Status: _____ Religion: _____ Education:_____**

**Occupation: _____ Military Service: _____**

**Current Diagnosis: _____ Height: _____ Weight: _____**

**Does applicant currently smoke? Yes / No**

**Has applicant had a previous stay(s) in the past year to the hospital or other nursing facility? Yes / No**

| **Date of Stay** | **Name of Facility** | **Reason/Services Received** |
|---|---|---|
| ___/___/___ | _____ | _____ |
| ___/___/___ | _____ | _____ |

**Has the applicant received any of the following services?**

____ **Home** Health Services _____ Geriatric Care Management _____ Adult Protective Services

____ Hospice _____ Attorney: If yes, name:_____

**Does the applicant have: Pre-paid burial? Yes / No Pre-selected Funeral Home? Yes / No**

**If Yes, Name:_____**

## II. INSURANCE

**Medicare Number: _____ Is Medicare Primary? Yes _____ No _____**

**If Medicare is not primary-other insurance:_____ Policy#_____**

**Supplemental Health Insurance: _____ Policy# _____**

**Pharmaceutical Plan: _____ Policy # _____**

**Long Term Care Insurance: Circle One Yes / No Has the policy been activated? Yes / No**

**If Yes, List Provider: _____ Policy # _____**

**Daily Amount: $_____ Total Value: $_____ Elimination Period:_____**

## III. RESPONSIBLE PARTY INFORMATION

**Healthcare Contact: List person holding the Healthcare Power of Attorney or the person who will be contacted for medical needs.**

**Is the Healthcare contact the same as the billing contact: Yes / No (if no, please complete section below)**

**Name: _____ Relationship: _____**

**Address: _____**

**Phone Numbers:**

**Home: _____ Work: _____ Cell: _____**

**E-Mail Address: _____**

**Financial Contact: (person who will be receiving the monthly bill):**

**Name: _____ Relationship: _____**

**Address: _____**

**Phone Numbers:**

**Home: _____ Work: _____ Cell: _____**

**E-Mail Address: _____**

**Other/Back-Up Emergency Contact:**

**Name: _____ Relationship: _____**

**Address: _____**

**Phone Numbers:**

**Home: _____ Work: _____ Cell: _____**

**E-Mail Address: _____**

## IV. FINANCIAL PROFILE

**Monthly Income**

**Social Security $_____ Monthly Rental Income $_____**

**Retirement/Pension $_____ Other: _____ $_____**

**Residence Does applicant own a home? Yes / No**

**Value (Approximate) $_____ Mortgage (Approximate) $_____**

**Is the property jointly owned? Yes / No Name of Co-Owner:_____**

**Assets (Current Balance)**

**Are the applicant's assets held individually? Yes / No If joint, with whom are they held?_____**

**Savings Account (s) $_____ Stocks/Bonds $_____**

**Checking Account (s) $_____ Life Insurance $_____**

**Certificates of Deposit $_____ Other (Describe) $_____**

***Has the applicant sold a home or transferred assets to anyone in the last 5 years? Yes_____ No_____**

**If Yes, please provide details:_____**

**Liabilities (Medical Bills, Credit Cards, Charge Accounts, Loans)**

**Dollar Total $ _____**

**Specify Liabilities: _____**

## Once admission confirmed, please provide the following:

- The front and back of all insurance cards;
- Copies of any Power of Attorney documents;
- Copies of any Guardianship documents;
- Copies of Living Will and or Advance Directives.

**I hereby attest that the above Financial Information is accurate and <u>assets are available for the Resident</u> to pay for services received at Rockville Nursing Home (RNH). It is understood that RNH relies on the accuracy and completeness of the information furnished in order to make an Admission Decision.**

**I understand that when Medicare coverage or other primary insurance benefits end, the resident will need to pay privately or be eligible for Maryland Medicaid. I certify that all information provided is accurate and complete as of this date, and I understand that any information provided will be used only for the application process and potential admission. I also direct and authorize Rockville Nursing Home to give and receive information from any medical or social work practitioner, social agency, clinic, hospital or nursing home where the resident has been or will potentially be treated.**

_____ _____

**Family / Responsible Party Signature** **Date**

**This application must be filled out completely in order to process your admission into our facility. If there is not a bed available at the time you submit this application or if you are not ready to admit your loved one, please feel free to check back with us on availability. All information will be kept confidential.**

**Rockville Nursing Home**
**303 Adclare Road**
**Rockville, Maryland 20850**

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**Fax (301) 279-5885**

**www.rockvillenursinghome.org**