Cranford Park
REHABILITATION AND HEALTH CARE CENTER
600 Lincoln Park East
Cranford, NJ, 07016
Office No. (908) 276-7100 Fax No. (908) 276-0173

SHORT-TERM ADMISSIONS APPLICATION

Please answer the following questions.

Name: _____ SSN: _____ Date:

_____

Address:

_____

___

Home Phone: _____ Work Phone:

_____

Cell Phone: _____ Email:

_____

Place of Birth: _____ Date of Birth:

_____

Occupation: _____ Marital Status: □ Single □ Married □ Divorced □

Widowed

Hospital Admitted From: _____ Length of stay at hospital:

_____

Emergency Contact: _____ Relationship:

_____

Address:

_____

___

Cell Phone: _____ Email:

_____

Comments:

_____

INSURANCE INFORMATION

Type of Plan: MRA _____ MRA HMO _____ MGC _____ HMO

_____

Primary: **In Network** ☐ YES ☐ NO

Plan Name: _____ Effective: _____

Policy No. _____ Group No. _____

Phone No. _____ Comments:

_____

Secondary: ☐ N/A **In Network** ☐ YES ☐ NO

Plan Name: _____ Effective: _____

Policy No. _____ Group No. _____

Phone No. _____ Auth. Req. ☐ YES ☐ NO

Authorization No. _____ Dates: _____

Level of Care: _____ Cover Co Pay's for Primary? ☐ YES ☐ NO

Amount of days covered _____ Comments:

_____

Coinsurance Payment Verification

☐ Private Pay ☐ Secondary Insurance: Supplemental Plan

Who is the coinsurance payer for HMO or Medicare?

Insurance Name: _____

Insurance Phone No: _____

ID No: _____

Does the coinsurance cover day 21-100 at 100% in a skilled nursing facility:

_____

Please attach copies of the residents SSC, Medicare card and all other insurance cards.

Please **initial** *to the following statement if it's applicable to you*

_____ I, resident/power of attorney/applicant representative, will be held financially responsible for the 20% of the co-insurance days for Medicare. I understand the first 20 days are 100% covered by Medicare and 21-100 days' Medicare imposes a 20% co-insurance payment.

By signing below, I certify that the information provided by me is true.

_____

_____

Applicant/Resident Date

_____

_____Responsible Party

Date

_____

_____

Signature of Witness Date

Cranford Park
REHABILITATION AND HEALTH CARE CENTER
600 Lincoln Park East
Cranford, NJ, 07016
Office No. (908) 276-7100 Fax No. (908) 276-0173

LONG-TERM CARE ADMISSIONS APPLICATION

Upon Admission: ☐ *Sub-acute to Long Term Care* ☐ *Long Term Care*

Please answer the following questions.

Name: _____ SSN: _____ Date:

_____

Address:

_____

(Street, City, Zip)

Home Phone: _____ Work Phone:

_____

Cell Phone: _____ Email:

_____

Place of Birth: _____ Date of Birth:

_____

Religion: _____ Language Preference:

_____

US Veteran: ☐ Yes ☐ No If yes, Branch of Service:

_____

Occupation: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐

Widowed

Spouses Name: _____

Address:

_____

(Street, City, Zip)

Home Phone: _____ Work Phone:

_____

Cell Phone: _____ Email:

_____

Hospital Admitted From: _____ Length of stay at hospital:

_____

Choice of Funeral Director: _____ Phone No.

_____

Address:

_____

Does Resident have a prepaid burial trust? □ Yes □ No □ In Progress

Has resident designated a Power of Attorney? □ Durable (Medical&Financial) □ Financial □ Medical

Power of Attorney (*Please be advised proof of POA is required*)

Name: _____ Relationship:

_____

Address:

_____

(Street, City, Zip)

Home Phone: _____ Work Phone:

_____

Cell Phone: _____ Email:

_____

Responsible Party

Name: _____ Relationship:

_____

Address:
_____
___

(Street, City, Zip)

Home Phone: _____ Work Phone:

_____

Cell Phone: _____ Email:

_____

Emergency Contact

Name: _____ Relationship:

_____

Address:
_____
___

(Street, City, Zip)

Home Phone: _____ Work Phone:

_____

Cell Phone: _____ Email:

_____

Name: _____ Relationship:

_____

Address:

_____
___

(Street, City, Zip)

Home Phone: _____ Work Phone:

_____

Cell Phone: _____ Email:

_____

INSURANCE INFORMATION

Type of Plan: MRA _____ MRA HMO _____ MGC _____ HMO _____

MCD _____ MLTSS _____

Primary: **In Network** ☐ YES ☐ NO

Plan Name: _____ Effective: _____

Policy No. _____ Group No. _____

Phone No. _____ Comments:

_____

Secondary: ☐ N/A **In Network** ☐ YES ☐ NO

Plan Name: _____ Effective: _____

Policy No. _____ Group No. _____

Phone No. _____ Auth. Req. ☐ YES ☐ NO

Authorization No. _____ Dates: _____

Level of Care: _____ Cover Co Pay's for Primary? ☐ YES ☐ NO

Amount of days covered _____ Comments:

_____

Coinsurance Payment Verification

☐ Private Pay ☐ Secondary Insurance: Supplemental Plan

Who is the coinsurance payer for HMO or Medicare?

Insurance Name: _____

Insurance Phone No: _____

ID No: _____

Does the coinsurance cover day 21-100 at 100% in a skilled nursing facility:

_____

Please attach copies of the residents SSC, Medicare card and all other insurance cards.

Please ***initial*** *to the following statement if it's applicable to you*

_____ I, resident/power of attorney/applicant representative, will be held financially responsible for the 20% of the co-insurance days for Medicare. I understand the first 20 days are 100% covered by Medicare and 21-100 days' Medicare imposes a 20% co-insurance payment.

By signing below, I certify that the information provided by me is true.

_____

_____

Applicant/Resident Date

_____

_____Power of Attorney/Responsible Party

Date

_____

_____

Signature of Witness Date

Resources Screening

Please answer the following below is applicable

SPOUSE'S INCOME MUST BE DISCLOSED TO DETERMINE MEDICAID ELIGIBILITY

Monthly Income

	Applicant	Spouse
Social Security Benefits	$_____	$_____
Veteran's Benefits	$_____	$_____
Pensions (specify)	$_____	$_____
Railroad Retirement	$_____	$_____
Annuity	$_____	$_____
Other (specify)	$_____	

$_____

Total Monthly Income: $

_____

Unearned Income

SSA Benefits $_____

$_____

Pension $_____

$_____

Support Benefits $_____

$_____

Other (specify) $_____

$_____

Total Unearned Income: $

_____

Liquid Resources

1. Cash ..... $

   _____

2. Bank Accounts

(1) Bank Address Account No.

_____

Type Joint (with) Balance

_____

(2) Bank Address Account No.

_____

Type Joint (with) Balance

_____

3. Stocks .....
   $_____
4. Bonds .....
   $_____
5. Mutual Funds .....

$_____

6. Other Liquid Resources .....
   $_____

Total Liquid Resources: $
_____

Non-Liquid Resources:

1. Real Estate-Property .....
   $_____
2. Vehicles .....
   $_____
3. Life Insurance (enter cash surrender) .....
   $_____
4. OTHER personal property (enter market value) .....
   $_____
5. Long Term Care Insurance .....
   $_____ Total Non-Liquid Resources:
   $ _____

By signing below, I _____ (resident/power of attorney/applicant representative) certify that the information provided true and accurate disclosure for the Residents' income, assets and resources. Proof of income and assets may be requested at any time. I, _____ (resident/power of attorney/applicant representative), understand responsibility to contact the Union County Board of Social Services to begin a Medicaid application if and when the Resident's assets are equal to or less than 3 months of billable charges. ***It has been advised to me, should there be any significant progress with the Medicaid application after 6 weeks of the resident being on Long Term Care, the case must be turned over to Application Pros.***

The Facility reserves the right to define "significant progress"

_____

_____

Applicant/Resident Date

_____

_____Power of Attorney/Responsible Party

Date

____

____

Signature of Witness Date