



CLAREMONT

Nursing & Rehabilitation Center

1000 Claremont Road . Carlisle . PA 17013-8805 . Main: 717.243.2031 . Fax: 717.240.1934 . www.ccpa.net/cnrc

ADMISSION APPLICATION: Claremont Nursing and Rehabilitation Center agrees that this application is confidential and will be used for processing purposes only. The information is applicable for all levels of care offered by CNRC. CNRC is in compliance with all federal HIPPA requirements and admits and treats all persons without regard to race, color, national origin, age, ancestry, sex, disability or religious creed.

Information about person applying to Claremont: (please print or type)

First name: _____ Last name: _____ Middle initial: _____

Permanent address: _____

Phone: Home (____) _____ Cell: (____) _____

Social Security # _____ Race/Ethnicity: _____

Is the applicant a United States citizen? _____

Birth date: _____ Marital status: _____

Spouse name (even if deceased): _____ Spouse's Social Security #: _____

Did applicant or spouse serve in military? ___ Yes (Applicant) ___ Yes (Spouse) ___ No (Neither)

Branch: _____ Name of veteran: _____ Social Security #: _____

For veteran's benefit eligibility, please contact the Cumberland County Veterans Administration at 717-240-6179 or 717-240-6178.

Anticipated admission: ___ Short term (under 180 days) ___ Long term (over 180 days)

Is applicant hospitalized presently? ___ Yes ___ No If Yes, Admission date: _____

Hospital: _____ Social Worker: _____

Telephone #: _____

List other hospital and nursing home stays in the last 60 days:

Health insurance policy numbers:

Secondary Insurance: _____ Effective Date: _____

Does it include pharmacy benefits? ___ Yes ___ No

Medicare A: _____ Effective Date: _____

Medicare B: _____ Effective Date: _____

RX Coverage: _____

Medicaid in community: _____ PACE: _____

Long term care insurance: Policy Provider: _____

Policy Number: _____ Address: _____

Phone #: _____

Ambulance membership Name: _____ Phone #: _____

Monthly gross income:

Social Security: _____ Pension(s): _____

Annuity income: _____

Other: _____

Assets

Bank Name

Checking account: _____ Amount: _____

Checking account: _____ Amount: _____

Savings account: _____ Amount: _____

Savings account: _____ Amount: _____

Certificate of deposit bank: _____ Amount: _____

Cash and/or other investments: _____ Amount: _____

Life insurance – company: _____ Face Value: _____

Real estate – location: _____ Value: _____

Real estate – location: _____ Value: _____

Name(s) on deed: _____

Mobile Home: _____

Vehicle(s) – year/make/model: _____

List any and all assets that have been transferred/given away the past five years, including the dates of transfer:

Property: _____

Vehicle: _____

Cash gifts over \$500.00: _____

CD's: _____

Does the applicant have a will? Yes No

Executor's name: _____

Executor's address: _____

Executor's telephone #s: _____

Preferred funeral home: _____

Funeral home address: _____

Funeral home telephone #: _____

Are arrangements pre-paid? Yes No Irrevocable: Yes No

Burial plots: _____ Cemetery name and place: _____

Cremation: _____ Paid or unpaid: _____

Primary family contact person:

Name: _____ Relation: _____

Address: _____

Telephone #'s: Home: _____ Cell: _____ Work: _____

Email: _____

How do you prefer to be contacted? (Please number your selections in order of preference.)

____ Home phone May we leave a message at this number? Yes No

____ Work phone May we leave a message at this number? Yes No

____ Cell phone May we leave a message at this number? Yes No

____ Email: _____

Has applicant ever resided in another nursing home? Yes No If Yes, for how long? _____

Has applicant received in-patient psychiatric care in the past two (2) years? Yes No

Has applicant executed Healthcare Guidelines/Living Will? Yes No

Does applicant have Durable POA? Yes No

Name: _____

Address: _____

ACKNOWLEDGEMENT:

I/we understand that CRNC reserves the right to accept or reject any application consistent with the law. I/we certify that all of the information submitted on this application is true and correct and that submission of false information may constitute grounds for rejection of the application and discharge after admission.

Note: All applications will be on file for three (3) years

I/we accept and agree to the above conditions.

Signature of Applicant

Signature of Applicant #2

Signature of person completing application/relationship to applicant

Date

Please tell us how you heard about Claremont Nursing and Rehabilitation Center: (check all that apply.)

Family Member

Radio

Friend

Television

Neighbor

Internet

Newspaper

Other (describe) _____

Please print and fax or email form to the address or fax number on the first page. Thank you!