

Application for Admission



NURSING & REHABILITATION CENTER
299 Hurley Avenue ~ Rockville, Maryland 20850
phone: 301-762-8900 ~ fax: 301-838-0416
TTD for Disabled MD Relay Service phone: 800-735-2258

Complete the following information by printing in the data and signing the last page. Mail, fax, or deliver this application to Collingswood Nursing and Rehabilitation Center, later referred to as CNRC.

Admission date: _____

Room desired: Private Semi-Private

Legal name of prospective resident: _____

Address: _____

Phone number: _____ Marital status: _____ Age: _____ Sex: _____

Date of birth: _____ Social Security #: _____

Medicare #: _____ Part A (Hospital) Part B (Medical)

Other insurance: _____ Policy #: _____

Address: _____ Phone: _____

Diagnosis: _____

History of mental illness: Yes No

Prospective resident is at: Home Hospital Other (specify) _____

Hospital's name: _____ City: _____ State: _____

Last dates of residing in a *skilled* nursing home: _____

Is resident being admitted: Short term Long term

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Financial Profile

To establish that a resident has adequate financial resources for payment of services, for purposes of long-term planning, please complete the following:

MONTHLY INCOME

Social Security	\$ _____
Retirement / Pension	\$ _____
Annual Rental Income	\$ _____

RESIDENCE (if resident owns)

Value (approximate)	\$ _____
Mortgage (approximate)	\$ _____

ASSETS (current balance of)

Savings Account(s)	\$ _____
Checking Account(s)	\$ _____
Stocks	\$ _____
Bonds	\$ _____
Certificates of Deposit	\$ _____
Other (describe)	\$ _____

LIABILITIES (Medical bills, credit cards, charge accounts, loans)

Dollar Total	\$ _____
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Specify Liabilities: _____

I hereby attest that the above financial information is accurate and assets are available to the resident to pay for services received at CNRC. It is understood that CNRC relies on the accuracy and completeness of the information furnished in order to make an admission decision.

Responsible Party's Signature

Date