



# Greenwood House

53 Walter Street, Ewing NJ 08628 Phone # (609)883-5391 Fax # (609)530-1635

1. Name: \_\_\_\_\_

2. Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: \_\_\_\_\_ Years at Present Address: \_\_\_\_\_

If Less Than 2 Years, Previous Address: \_\_\_\_\_

3. Marital Status:  Single  Married  Divorced  Widowed

4. Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Birthplace: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

5. Medicare # \_\_\_\_\_ Social Security # \_\_\_\_\_ Medicaid # \_\_\_\_\_

Health Insurance Co.: \_\_\_\_\_ ID # \_\_\_\_\_

6. With whom are you now living? \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_

### 7. Names & Addresses of Children:

1) Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work# \_\_\_\_\_

Email: \_\_\_\_\_

2) Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work# \_\_\_\_\_

Email: \_\_\_\_\_

3) Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work# \_\_\_\_\_

Email: \_\_\_\_\_

4) Name: \_\_\_\_\_ Address: \_\_\_\_\_

Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work# \_\_\_\_\_

Email: \_\_\_\_\_

### 8. Other Relatives or Interested Friends:

Name: \_\_\_\_\_ Name: \_\_\_\_\_

Name: \_\_\_\_\_ Name: \_\_\_\_\_

### 9. Do you receive any Pension, Private or Governmental payments, including Medicaid, Social Security?

Yes  No If yes, please itemize source & amount (Monthly):

Source \_\_\_\_\_ Amount \_\_\_\_\_ Source \_\_\_\_\_ Amount \_\_\_\_\_

Source \_\_\_\_\_ Amount \_\_\_\_\_ Source \_\_\_\_\_ Amount \_\_\_\_\_

10. Is your Life Insured?  Yes  No  
Amount: \_\_\_\_\_ Company: \_\_\_\_\_  
Beneficiary: \_\_\_\_\_ Policy # \_\_\_\_\_

11. Are there any friends or relatives who will help in the maintenance of your personal wardrobe,  
medical expense, burial expense, etc.?  Yes  No  
Name & Address: \_\_\_\_\_

12. What serious illnesses have you had in the past 5 years? \_\_\_\_\_  
\_\_\_\_\_

Name & Address of Physician who last attended you: \_\_\_\_\_  
Date of Last Visit: \_\_\_\_\_

Who is your family physician? \_\_\_\_\_

Have you been a resident of any other Home?  Yes  No  
If yes, give name, address: \_\_\_\_\_

Date of Residency: \_\_\_\_\_

Have you ever filed an application to any other Home?  Yes  No  
If rejected, please state reason: \_\_\_\_\_

13. Do you have burial benefits?  Yes  No

14. Do you have a Living Will?  Yes  No

15. Funeral Arrangements: \_\_\_\_\_

Please provide copies of all:

- Social Security  Medicare  Medicaid  Medical & Prescription Insurance Cards

If admitted, I will abide by the rules of Greenwood House and apply for any governmental aid programs which may be necessary. I agree to complete any statements required for the admission process.

A non-refundable processing fee of \$50.00 is required with the filing of this application.  
If unable to pay fee, please consult with the Executive Director.

Applicant's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Co-Signer (Children or those responsible): \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_ Date: \_\_\_\_\_

**State of New Jersey Department of Human Services Division of Medical Assistance and Health Services**  
Governor Thomas H. Kean signed a law on August 23, 1985 which is important to persons seeking admission to a Medicaid Nursing Home. It prohibits nursing homes from denying admission to a Medicaid applicant if a bed is available and the home is below a specific occupancy level. The law also prohibits nursing homes from requiring any payment from a Medicaid eligible person or his/her family as a condition for admission or for a continued stay at a nursing home.  
The Medicaid District Office should be notified immediately if this law is not followed.