



ATTENTION

Please read prior to completing the
Admission Application:

When completing the **Admission Application**,
please fill it out in its **entirety and be sure to
supply a copy of all bank statements**

Thank you for your interest in our Home.



Name of Person Completing this Application: _____

Relation to Applicant: _____

Date: _____

1. PERSONAL INFORMATION

Name of Applicant in full: _____

Maiden Name (if applicable): _____

Applicant Contact Number: _____

Address of Applicant: _____

Date of Birth: _____ Social Security #: _____

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Gender Pronouns: ☐ He, Him, His ☐ She, Her, Hers ☐ Sie, Hir, Hirs ☐ They, Them, Theirs

Place of Birth: _____ Religion: _____

2. EASTERN STAR OR MASONIC MEMBERSHIP: YES NO

If yes, complete below:

Chapter: _____ Chapter #: _____ District #: _____

Masons: Lodge: _____ Lodge #: _____ State: _____

Date of Initiation: _____ Number of years of consecutive membership: _____

If no, are you related to an Eastern Star Member or Mason? YES NO

Name of Relative: _____ Relationship: _____



3. EMERGENCY CONTACT INFORMATION / NEXT OF KIN

1st Name: _____ Relationship: _____
Address: _____
Mobile Number: _____ Work Number: _____
Home Number: _____ ☐ POA ☐ Healthcare Proxy
Email Address: _____

2nd Name: _____ Relationship: _____
Address: _____
Mobile Number: _____ Work Number: _____
Home Number: _____ ☐ POA ☐ Healthcare Proxy
Email Address: _____

3rd Name: _____ Relationship: _____
Address: _____
Mobile Number: _____ Work Number: _____
Home Number: _____ ☐ POA ☐ Healthcare Proxy
Email Address: _____

4. HEALTH INSURANCE

Primary Insurance: _____ ID #: _____
Secondary Insurance: _____ ID #: _____
Other Insurance: _____ ID #: _____
Prescription Plan: _____ ID#: _____
LTC Insurance: _____



Please make sure to provide copies of the insurance cards or LTC policy.

5. LEGAL RESOURCES

Do you have an Attorney? **NO** **YES:**

Name: _____ Phone #: _____

Address: _____

Note: A Power of Attorney should be obtained prior to admission to the Home in the event you are unable to execute your own affairs. Authority granted must include handling of all financial affairs, legal affairs, decisions for medical treatment, and surgical care. You must submit a copy of your executed Power of Attorney to the Director of Social Services or to the Admissions office. You DO NOT need an attorney to complete a Power of Attorney, you DO need to have the document notarized in order for it to be valid. We can provide you with a standard NJ Power of Attorney Form should you need it.

Do you have a Power of Attorney? **NO** **YES:**

Name: _____

Address: _____

Phone Number: _____ Financial POA ☐ Healthcare Proxy ☐

If you have multiple Power of Attorney, please list name's, phone number and addresses below:

9. ADVANCE DIRECTIVE

Do you have an Advance Directive / Living Will? **YES** ☐ **NO** ☐

If you have an Advance Directive / Living Will, please submit a copy prior to admission. You will be provided with information on Advanced Directive upon admission should you not have one.



10. FUNERAL ARRANGEMENTS

Name of Funeral Home: _____

Address: _____

Phone #: _____

Do you have a Pre-Paid Funeral Trust? **NO** ☐ **YES** ☐

****If you have a pre-paid funeral trust, please make sure that it is listed as IRREVOCABLE****

11. FINANCIAL INFORMATION

**** All financial information disclosed below is CONFIDENTIAL AND SECURE. This information is used to help us determine the Financial Status of the applicant. ****

Does the Applicant own a Home? **NO** ☐ **YES** ☐

If **yes**, please provide the address: _____

Is the Applicant the Sole Owner of the Home? **NO** ☐ **YES** ☐

If **no**, please provide the name & relationship of the Co-owner:

If the applicant owns multiple properties, please list them below along with ownership detail.

In the last Five (5) years, has the applicant gifted or transferred money or assets?

NO ☐ **YES** ☐ ****This question allows us to evaluate for Medicaid eligibility. ****

If Yes, please explain below:

Income:

Social Security: _____

Pension: _____

Pension: _____

Other Income: _____

TOTAL: _____



Any other income information: _____

Liabilities: Does the patient have a mortgage, money owed, debt? **NO** ☐ **YES** ☐

CAPITAL ASSETS

Savings Account: _____ last month balance
Checking Account: _____ last month balance
Other Account: _____ last month balance
Other Account: _____ last month balance
Other Account: _____ last month balance

Last month statement **MUST** be provided in order to verify the information being reported on this document. All financial statements provided are kept **CONFIDENTIAL**. The information that is being requested is to help us determine if the applicant will be eligible for Medicaid services.

By affixing my signature to this application, I hereby affirm that I have not transferred any real and/or personal assets or property within the last 60-month period, nor will I transfer any real and/or personal property held by me, for less than fair market value, for as long as this application is in process.

In the event that any of my assets or property have been transferred or sold within the last 60-months, I have provided a complete disclosure of such transactions below in the space provided or have attached a complete explanation in an addendum.

Disclosure of all transferred assets: _____



I understand that a transfer of assets or property (without compensation at fair market value) will be considered in determining admission eligibility.

I request consideration for admission to the New Jersey Eastern Star Home with the understanding that all income, real and/or personal assets belonging to me, the applicant, will be considered available as payment for care and services.

I hereby affirm that the information on this application is true and correct.

Applicant (Responsible Party) Signature

Applicant (Responsible Party) Print

Date Signed

Please return to:
Shelretha LaSure, Director of Admissions & Business Development
111 Finderne Ave Bridgewater, NJ 08807
Fax: 908-722-9566 Email: slasure@njeasternstarhome.com



MEDICAL CERTIFICATE

COMPLETED BY FAMILY PHYSICIAN

Patient Name:

(Last) (First) (Middle)

Patient Home Address:

Date of Birth: _____ Sex: ☐ Female ☐ Male

Preferred Pronouns: _____

Advanced Directive / Living Will ☐ Yes ☐ No

Name/Address of Primary Hospital:

Primary Diagnosis:

History & Physical:



Most Recent Hospital Stay & Reason:

Physical Condition: ☐ Good ☐ Fair ☐ Poor

Height: _____ Weight: _____ ☐ Continent ☐ Incontinent ☐ Foley

Ambulatory Status: ☐ Independent ☐ w/Assistive Device ☐ Bedridden

Mental Status: ☐ Alert _____ (x1,2,3) ☐ Confused ☐ Depressed

Behaviors: ☐ Verbally Abusive ☐ Physically Combative ☐ None

If patient has behaviors please explain:

Psychiatric History: ☐ None ☐ Yes – please explain:

Allergies: _____

Is the patient free from communicable diseases? ☐ Yes ☐ No – Please explain



Vaccinations: Please provide documentation

Pneumovax ☐ No ☐ Yes Date: _____

Flu Vaccine: ☐ No ☐ Yes Date: _____

PPD: ☐ No ☐ Yes Date: _____

COVID Vaccine ☐ No ☐ Yes Type: _____

Date: _____

Recent Labs (within 3 months) ☐ No ☐ Yes (please provide a copy)

***** Please provide a copy of current Medication List *****

Primary Emergency Contact/POA:

Address:

Home phone: _____ Cell phone: _____

Fax: _____

Email Address:

Comments:



I recommend long term care placement for this patient: ☐ YES ☐ NO

Physician Signature

Date of Exam

Please email this form to slasure@njeasternstar.org

Fax to: 908-722-9566 Attn: Shelretha LaSure

Please include any supporting documentation

111 Finderne Avenue, Bridgewater, NJ 08807