



Calvert Manor Healthcare Center
1881 Telegraph Road
Rising Sun, MD 21911
Phone: (410) 658-6555
Fax: (410) 658-9717
TDD: (800) 735-2258

APPLICATION FOR ADMISSION

Date _____

Resident's Name _____

Home Address _____

City _____ County _____ State/Zip _____

Age _____ Birth date _____ Place of Birth (county/state) _____

Marital Status _____ Religion _____

Referred to Calvert Manor by _____

Current Location ____ Home ____ Hospital ____ Nursing Home ____ Other (specify) _____

Current Location Information (If other than home):

Facility Name _____ Phone _____

Address _____

Date of Admission _____ Contact Person _____ Telephone # _____

Resident's Physician _____

Address _____

Telephone _____

HEALTH INSURANCE:

Social Security # _____ Medicare # _____ Part A _____ Part B _____

Part D _____ (If yes, name of insurer) _____

Commercial Insurance: Name _____

Address _____

Telephone # _____ Policy # _____

Premium _____ Frequency _____

RESIDENT'S FINANCIAL AGENT:

Name _____ Relationship to Resident _____

Home Address _____

City _____ State Zip _____

Telephone (Home) _____ (Business) _____ (Cell) _____

ADVANCE DIRECTIVES:

Has anyone been appointed Power of Attorney YES ____ NO ____ Guardian: YES __ NO __

Type of Power of Attorney or Guardianship _____

Has a Living Will been prepared? YES _____ NO _____

Has anyone been appointed Health Care Agent? YES _____ NO _____

Name _____ Address _____

Telephone # _____ Relationship _____

MEDICAL INFORMATION:

Diagnosis _____

Medications _____

Allergies _____

Flu Vaccine: YES _____ NO _____ Date _____

Pneumovax: YES _____ NO _____ Date _____

Dentures: Upper _____ Lower: _____ Glasses _____

Hearing Aid: Right _____ Left _____ Other _____

Hospital Preference _____

FINANCIAL RESOURCES:

Assets:

Monetary: \$ _____

Real Estate: \$ _____

Life Insurance:\$ _____

Income:

Social Security:\$ _____

Pension: \$ _____

Other: \$ _____

MEDICAID/MEDICAL ASSISTANCE:

Has the resident applied, or will the resident shortly be applying for, Long Term Care Medical Assistance?

YES _____ NO _____ Medicaid # _____

If the resident has applied, what was the date? _____ County

Dept. Of Social Services Representative _____ Telephone

Signature of Resident _____ Date: _____

Signature of Resident's Agent
Submitting this Application _____ Date: _____

Address _____ Telephone _____

Relationship _____