DeKalb TOWNSHIP
2323 South Fourth Street - DeKalb, IL 60115

Mary Hess, Supervisor
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APPLICATION FOR ADMISSION TO:
DEKALB COUNTY REHAB AND NURSING CENTER
2600 North Annie Glidden, DeKalb, Il. 60115

TWO (2) YEAR RESIDENCY REQUIREMENT

APPLICANT INFORMATION: TOWNSHIP: **DEKALB**

NAME: _____ ADDRESS: _____
STREET CITY STATE ZIP CODE

_____ PHONE: _____ DATE OF BIRTH _____ MALE ☐ FEMALE ☐
Length of Residency at this address

Please complete: (If you have not resided at the above address for 2 yrs., please complete the following.)

Previous Address: _____ From _____ To _____

Previous Address: _____ From _____ To _____

Type of Payment: Medicare ☐ Private ☐ Public Aid ☐

Reason for placement or other comments: _____

_____

_____

Signature: _____ Date: _____
(Applicant, Family Member or other person completing this form)

PLEASE COMPLETE THE CONTACT NAMES ON THE BACK OF THIS FORM. PLEASE PRINT CLEARLY. COMPLETE IN BLUE OR BLACK INK. THANK YOU.

1) Please provide as many telephone numbers as possible for each Contact Person. We will call every number listed for each person. Due to time restraints we do not leave messages on recorders. If we are unable to reach any of the Contact Person(s), we will place the application at the bottom of the list and move on to the next application.

2) When our office calls the Contact Person, we require a response. Please advise Contact Person(s) to respond with an affirmative answer if placement is desired. Attach additional sheet if more than two contact people will be used.

APPLCH

OVER

DATE RECEIVED: _____ ENTERED ON COMPUTER _____

Applicant's Name_____

First Contact : Name: _____ Relationship: _____

Phone: Home _____ Work _____ Cell _____

Address: _____
STREET CITY STATE ZIP CODE

Additional Contact: Name _____ Relationship: _____

Phone: Home _____ Work _____ Cell _____

Address: _____
STREET CITY STATE ZIP CODE
