



YOU HAVE CONTACTED THIS FACILITY AND INDICATED A DESIRE TO BE ADMITTED AS A RESIDENT. BECAUSE OF THIS, YOU HAVE ALREADY BEEN ISSUED A RECEIPT INDICATING THE DATE AND TIME OF YOUR INITIAL REQUEST AND YOUR NAME HAS BEEN PLACED ON OUR DATED LIST OF APPLICATIONS OR INQUIRY LIST. PLEASE FIND ENCLOSED THIS FACILITY'S WRITTEN APPLICATION FORM. AS SOON AS YOU SUBSTANTIALLY COMPLETE AND RETURN THE FORM, YOUR NAME WILL BE PLACED ON OUR WAITING LIST.

ADMISSION APPLICATION

I. VITAL STATISTICS

Resident Name : _____
Home Address : _____ Phone : _____
Present Location : _____ If hospital date of admit : _____
Date of Birth : _____ Birthplace : _____
Marital Status : _____ Religion : _____
Former Occupation : _____
Hospital Preference : _____
Pharmacy Preference : _____

II. RESPONSIBLE PARTIES

Person Managing Finances : _____
Address : _____
Phone : (home) _____ (work) _____

EMERGENCY CONTACT:

Name : _____ Relationship : _____
Address : _____
Phone : (home) _____ (work) _____
Name : _____ Relationship : _____
Address : _____
Phone : (home) _____ (work) _____

III. FINANCIAL DATA

Social Security # : _____ Medicare # _____
Medicaid # : _____ Pending : _____
Type of Insurance : _____

IV. MISCELLANEOUS

Community Physician : _____ Phone : _____
Do you have an ADVANCE DIRECTIVE ? : _____
Have you made arrangements to be an ORGAN DONOR ? : _____

MEDICAL DATA

Name _____
Current Physician _____ Will physician be following? Yes ___ No ___
Current Diagnosis _____
Past Medical History _____
Medications _____
Nursing Needs (Indicate all that apply)

| | | | |
|--|--|---|--------------------------------------|
| <u>Ambulation</u> | <u>Continance</u> | <u>Feeding</u> | <u>Bathing</u> |
| <input type="checkbox"/> Independent | <input type="checkbox"/> Continent | <input type="checkbox"/> Independent | <input type="checkbox"/> Independent |
| <input type="checkbox"/> With Assist | <input type="checkbox"/> Incontinent | <input type="checkbox"/> With Assist | <input type="checkbox"/> With Assist |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Bowel | <input type="checkbox"/> Total Assist | <input type="checkbox"/> Total care |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Bladder | <input type="checkbox"/> Feeding Tube | |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Foley catheter | <input type="checkbox"/> NG | |
| <input type="checkbox"/> Bedbound | <input type="checkbox"/> Texas catheter | <input type="checkbox"/> Gastric | <u>Dressing</u> |
| <input type="checkbox"/> Transfers | <input type="checkbox"/> Sup. Pub. cath. | <input type="checkbox"/> J-tube | <input type="checkbox"/> Independent |
| <input type="checkbox"/> Ind. | <input type="checkbox"/> Ostomy (Type) _____ | <input type="checkbox"/> Rate _____ | <input type="checkbox"/> With Assist |
| <input type="checkbox"/> Assist Of _____ | | <input type="checkbox"/> Solution _____ | <input type="checkbox"/> Total care |
| 1 {} 2 {} | | <input type="checkbox"/> Special Diet _____ | |

Adaptive Equipment: (type) _____

| | | |
|---|---|------------------------|
| <u>Mental Status</u> | <u>Behavior</u> | <u>Misc.</u> |
| <input type="checkbox"/> Alert | <input type="checkbox"/> Cooperative | Weight _____ |
| <input type="checkbox"/> Understands | <input type="checkbox"/> Depressed | Height _____ |
| <input type="checkbox"/> Forgetful | <input type="checkbox"/> Withdrawn | Hearing Impaired _____ |
| <input type="checkbox"/> Confused | <input type="checkbox"/> Belligerent | Speech Impaired _____ |
| <input type="checkbox"/> Non Responsive | <input type="checkbox"/> Noisy | Vision Impaired _____ |
| <input type="checkbox"/> Oriented | <input type="checkbox"/> Needs Restraints | Dentures _____ |
| <input type="checkbox"/> Disoriented | <input type="checkbox"/> Wanders | Allergies _____ |
| | <input type="checkbox"/> Combative | Skin: Intact _____ |
| | | Reddened _____ |
| | | Open area _____ |
| | | Size _____ |
| | | Oxygen _____ |

Therapies Received _____ Therapies Needed ___ P.T. ___ O.T. ___ Speech
Treatments _____

Other Pertinent Medical Information: _____

FINANCIAL DISCLOSURE

All information supplied shall remain confidential. Application cannot be processed without this form.

Social Security # _____ Medicare # _____ A__ B__
Title 19 # _____ Case Worker(if pending) _____
Was applicant or spouse a member of the U.S. Armed Forces? _____
Medical Insurance # _____ Phone # _____
Other Insurance _____ Phone _____
Current monthly income (from all sources)
\$ _____

How will the stay be financed? (circle one)

1. Medicare 2. Insurance & Private Funds 3. Insurance only
4. Private Funds 5. Medicaid(T-19)

Current Liquid Assets (checking, savings, securities) \$ _____

Non-Liquid Assets (stocks, bonds, land, houses, IRA's etc.)\$ _____

Has there been any transfer of assets (liquid/non-liquid) within the last 36 months? _____ If yes, please specify amount & to whom. _____

Has applicant been in another nursing facility within the past year? ___ YES ___ No

If yes, where and when? _____

We will need copies of the following: (We will copy for you if desired)

Medicare Card Health Insurance Cards Power of Attorney
Appointment of Conservator Living Wills Health Care Agent

RESPONSIBLE PARTY INFORMATION:

Party responsible for handling bills:

Name _____ Address _____
Business Phone _____ Home Phone _____
Relationship _____ Conservator _____
Power of Attorney _____
Health Care Agent _____

Thank you for taking the time to complete this application.

Signature of person completing the form _____
Relationship to Applicant _____ Date _____

We are required by law to obtain from each applicant prior to admission a signed statement showing the applicant's understanding of the fact that this nursing home participates in the Medicaid and Medicare programs. We must also provide the applicant with our policy regarding advance payment and deposits. This notice must be signed and returned to us before we can admit any applicant. The notice must be signed by the applicant if he/she is capable of understanding it. If a Conservator of the Person has been appointed for the applicant, the Conservator should sign. If the applicant is not capable of understanding this Notice and no Conservator has been appointed, anyone authorized to act for the applicant under a Power of Attorney or the person acting as the responsible relative of the applicant should sign.

THIS NURSING HOME PARTICIPATES IN THE MEDICAID (TITLE XIX) PROGRAM AND HAS A PROVIDER AGREEMENT WITH THE STATE OF CONNECTICUT TO PROVIDE CARE AND SERVICES TO MEDICAID ASSISTED PATIENTS. ELIGIBILITY FOR MEDICAID ASSISTANCE IS DETERMINED BY THE STATE OF CONNECTICUT DEPARTMENT OF INCOME MAINTENANCE, BASED ON EACH PATIENT'S FINANCIAL RESOURCES.

THIS NURSING HOME ALSO PARTICIPATES IN THE MEDICARE (TITLE XVIII) PROGRAM AND HAS A PROVIDER AGREEMENT WITH THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES TO PROVIDE CARE AND SERVICES TO PATIENTS WHO ARE ELIGIBLE FOR MEDICARE BENEFITS. ELIGIBILITY FOR MEDICARE BENEFITS IS DETERMINED ACCORDING TO RULES ESTABLISHED BY THE SECRETARY OF HEALTH AND HUMAN SERVICES, BASED ON THE TYPE OF CARE THAT IS NEEDED AND WHETHER OTHER REQUIREMENTS, SUCH AS PRIOR THREE-DAY HOSPITAL STAY ARE MET.

NOTICE OF ADVANCE PAYMENT AND DEPOSIT REQUIREMENTS

1. IF YOU WILL BE PAYING FOR YOUR CARE FROM YOUR OWN FUNDS, WE REQUIRE A SECURITY DEPOSIT EQUAL TO ONE MONTH'S PER DIEM RATE. THE FACILITY ALSO REQUIRES A PRORATED AMOUNT OF THE TOTAL PER DIEM RATE TO COVER CARE PROVIDED FROM THE ADMISSION DATE TO THE END OF THE MONTH. IN ADDITION, WHEN A RESIDENT IS ADMITTED WITHIN THE LAST FIFTEEN (15) DAYS OF ANY MONTH, THE RESIDENT AGREES TO PAY AT THE TIME OF ADMISSION THE TOTAL PER DIEM RATE FOR THE NEXT SUCCEEDING MONTH'S SERVICES. THEREAFTER, YOU WILL BE BILLED IN ADVANCE ON OR ABOUT THE 15TH OF EACH MONTH FOR PER DIEM CHARGES FOR THE FOLLOWING MONTH, AND ANY ACCRUED ANCILLARY CHARGES.

2. IF YOUR CARE WILL BE COVERED BY MEDICARE, THERE IS NO REQUIRED ADVANCE PAYMENT OR DEPOSIT. WE WILL BILL YOU AT THE END OF EACH MONTH FOR ANY COINSURANCE CHARGES THAT HAVE BECOME DUE AND ANY ITEMS OR SERVICES NOT COVERED BY MEDICARE.

3. IF YOU ARE ELIGIBLE FOR MEDICAID ASSISTANCE AT THIS TIME THERE IS NO REQUIRED ADVANCE PAYMENT OR DEPOSIT. WE WILL BILL YOU, OR CHARGE YOUR PERSONAL ACCOUNT, FOR ITEMS AND SERVICES NOT COVERED UNDER MEDICAID AT THE END OF EACH MONTH FOR ANY SUCH CHARGES ACCRUED DURING THAT MONTH.

4. IF YOU HAVE AN APPLICATION FOR MEDICAID ASSISTANCE FILED WITH THE DEPARTMENT OF INCOME MAINTENANCE PRIOR TO ADMISSION, YOU WILL BE BILLED CHARGES, AT THE END OF EACH MONTH UNTIL YOUR APPLICATION IS APPROVED. IF MEDICAID ASSISTANCE IS APPROVED

RETROACTIVELY FOR ANY CARE AND SERVICES FOR WHICH YOU HAVE BEEN BILLED, AN APPROPRIATE ADJUSTMENT OR REFUND WILL BE MADE PROMPTLY.

ALL BILLS FROM THIS FACILITY ARE DUE AND PAYABLE UPON RECEIPT. IF YOU HAVE MADE A DEPOSIT OR ADVANCE PAYMENT AND ARE ENTITLED TO A REFUND FOR ANY REASON, REFUNDS WILL BE IN ACCORDANCE WITH APPLICABLE LAW.

I have read this notice and understand that participates in both the Medicaid and Medicare programs. I also understand the facilities policies regarding advance payments and security deposits.

Signed _____
(Applicant) (Conservator of Person/POA)

Date _____