Eliza Huntington
MEMORIAL HOME

Administrator: Tina M Yeitz
Director of Resident Care: Sandra Hill
Business Manager: Christine Longo

APPLICATION FOR ADMISSION

GENERAL INFORMATION

Name of Applicant: _____
Home Address: _____ Home Phone # (____) _____
Date of Birth_____/_____/_____ Marital Status_____ Sex_____
Religion/Parish: _____ Birthplace: _____

Name/Addresses of Children:
_____
_____
_____

Name/Addresses of Brothers and Sisters:
_____
_____
_____

Former Occupation of Applicant: _____
Highest Level of Education Completed: _____
Other Languages Spoken: _____
Hobbies and Interests: _____
Special Talents: _____

Responsible Party for Financial Decisions:
Name: _____ Address: _____
Home Phone: _____Cell: _____Work: _____
Relationship to Applicant: _____ POA ____ Conservator of Person ____

Primary person to contact in case of emergency (Medical Decisions):
Name: _____Address: _____
Home Phone: _____Cell: _____Work: _____
Relationship to Applicant: _____ POA ____ Conservator of Person ____

Eliza Huntington
MEMORIAL HOME

Alternate contact person:
Name: _____Address: _____
Home Phone: _____Cell: _____Work: _____
Relationship to Applicant: _____ POA ____ Conservator of Person ____

If applicant is in a medical facility at present, please complete the following:
Name of Facility: _____ Date of Admission_____/_____/_____
Address of Facility: _____

MEDICAL INFORMATION
Primary Care Physician: _____Address/Phone:_____
Primary Diagnosis: _____Allergies: _____
Reason for Placement: _____Recent Hospitalizations: _____
Height: _____ Weight: _____

Current Medications:

MEDICATION NAME	DOSAGE	FREQUENCY

Other Physicians providing Care: Dentist, Ophthalmologist, Specialists etc.

Type of Physician: _____Name:_____ Phone: _____

Type of Physician: _____Name:_____ Phone: _____

Type of Physician: _____Name:_____ Phone: _____

Eliza Huntington
MEMORIAL HOME

Dietary Requirements:
_____

Food Dislikes/Food Allergies:
_____

Favorite Foods:
_____

Does applicant prefer:
_____ Being Alone _____ Being with a Group ____ Quite Lifestyle _____ Active Lifestyle

Does applicant have any emotional problems (depression, anger, mood changes): ❑YES ❑NO

What assistance is required with personal care: (Please check if applicable)

Bathing: _____ Medication Reminders: _____ Dressing: _____ Personal Hygiene: _____
Other: (please explain) _____

Bladder Incontinence: _____ Bowel Incontinence: _____

Does the applicant wear pads or garments for incontinence? _____

Vision: Good ____ Fair ____ Poor ____ Hearing: Good ____ Fair ____ Poor ____

Ambulation: Good ___ Fair ___ Poor ___

Does applicant use a: Cane ___ Walker ___ Wheelchair ____

Does the applicant have (please check all that is applicable):
Living will: ___ Advanced Directives: ___ POA: ___ Conservator: ____
Other (please explain): _____

(Please provide paperwork upon submission of Application for Admission)

Has the applicant been receiving any medical care from a related or non-related party while living in their home? ❑YES ❑NO

Eliza Huntington
MEMORIAL HOME

FINANCIAL INFORMATION
(Please provide a copy of cards)

Social Security #:_____ Medicare #:_____

Medicare Co-Pay #:_____ Medicare Supplement #:_____

Medicaid (State Medical Assistance) #: _____

Does the applicant have an application pending for State Medical Assistance (Title 19)?
❑YES ❑NO
If yes, please indicate:
Date application submitted: _____/_____/_____
District Office: Case Worker: _____

Is the applicant a Veteran? ❑YES ❑NO Spouse of a Veteran? ❑YES ❑NO

Is the applicant covered by any other medical or hospital insurance? ❑YES ❑NO
Name of Company: _____Identification # _____ Type of Insurance: _____

Do you own a Partnership-Approved Long-Term Care Insurance Policy? (This policy has been pre-certified under the Connecticut Partnership for Long-Term Care and provides Medicaid Asset Protection)? ❑YES ❑NO
If yes, with whom? _____
What is your current ID #_____

Does the applicant own life insurance? ❑YES ❑NO
If yes, Name of Company: _____
Cash Value $_____ Face Value $_____

Has an irrevocable burial account been established? ❑YES ❑NO
Name of Funeral Home: _____Amount $_____

Income - Applicant and spouse if applicable

Please list all income including but not limited to: Social Security, Supplemental Security Income, Pensions, VA Benefits, Workman's Compensation, Annuities, Rental Income, etc.

SOURCE	AMOUNT	PAYABLE TO WHOM

Cash Assets

Please list all assets including but not limited to: Savings Accounts, Checking Accounts, Stocks, Bonds, CD's, Trusts, Annuities, etc.

NAME OF INSTITUTION	ACCOUNT #	PRESENT BALANCE	LARGEST BALANCE IN THE PAST 36 MONTHS	WHO IS LISTED ON THE ACCOUNT

Eliza Huntington
MEMORIAL HOME

Real Estate

Does applicant own any real estate? ❑YES ❑NO If yes, please complete the following:

DESCRIPTION OF THE PROPERTY	APPROXIMATE VALUE	NAMES ON DEED/OWNERSHIP

Are there any liens or mortgages against the property? ❑YES ❑NO

If so, in the amount of $_____ payable to_____

Is anyone other than the applicant living in the home? ❑YES ❑NO

Transfer of Assets

Has the applicant transferred, sold, or given real estate, personal property, cash or any other assets in the past 60 months? ❑YES ❑NO

ITEM TRANSFERRED	VALUE	TO WHO	DATE OF TRANSFER

I certify that I have fully investigated the applicant's financial records and that this is a true and complete statement of the applicant's current income and assets and any gifts or transfers for less than fair market value, in excess of $1,000 that the applicant has made within the sixty (60) months prior to the date of this application.

_____ _____ _____ _____

Applicant Signature Date Responsible Party Signature Date

Eliza Huntington
MEMORIAL HOME

Responsibility Agreement

I understand that this is an Application for Admission to the Eliza Huntington Memorial Home of Norwich, Inc. By completing this application, I acknowledge, that this does not guarantee my admittance to the Eliza Huntington Home, nor does it in any way guarantee that I have been accepted onto the wait list of the Home. Acceptance and placement at the Home is the sole discretion of the Home's Administrator.

If accepted to the Home, I agree:

- To supply furnishing's and to bring an appropriate amount of clothing and personal belongings
- To have a telephone in my room at my own expense
- To abide by the discharge policies of the Home and upon the advice of my personal physician and/ or the Administrator of the Home, I will move my _____ to a more suitable facility.
- To pay the monthly fee on or before the first (1st) day of each month. I understand that the rate is subject to change at any time with a thirty (30) day notice.

Furthermore, I understand that if my _____receives Medicaid assistance, along with any pension, or social security income, that I will forward all applied income amounts to the Home on or before the first (1st) day of each month.

_____ _____ _____ _____

Applicant Signature Date Responsible Party Signature Date

Eliza Huntington
MEMORIAL HOME

SAMPLE ROOM DIAGRAM