



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 ____
Email address: _____

Primary person to contact in case of emergency (Medical Decisions):

Name: _____ Address: _____
Home Phone: _____ Cell: _____ Work: _____
Relationship to Applicant: _____ POA ____ Conservator of Person ____
Email address: _____



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Alternate contact person:

Name: _____ Address: _____

Home Phone: _____ Cell: _____ Work: _____

Relationship to Applicant: _____ POA _____ Conservator of Person _____

Email address; _____

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
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please attach Physician Orders

Physicians providing Care: Dentist, Ophthalmologist, Specialists etc.

Type of Physician: _____ Name: _____ Phone: _____

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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



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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 \$ _____



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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



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Real Estate

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

<u>DESCRIPTION OF THE PROPERTY</u>	<u>APPROXIMATE VALUE</u>	<u>NAMES ON DEED/OWNERSHIP</u>

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

<u>ITEM TRANSFERRED</u>	<u>VALUE</u>	<u>TO WHO</u>	<u>DATE OF TRANSFER</u>

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



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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



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SAMPLE ROOM DIAGRAM

