



**APPLICATION FOR ADMISSION
TO
WEST HARTFORD HEALTH & REHABILITATION CENTER**

YOU HAVE CONTACTED THIS NURSING HOME AND INDICATED A DESIRE TO BE ADMITTED AS A PATIENT TO THIS FACILITY. BECAUSE OF THIS, YOU HAVE BEEN ISSUED A RECEIPT INDICATING THE DATE AND TIME OF YOUR INITIAL REQUEST AND YOUR NAME HAS BEEN PLACED ON OUR DATED INQUIRY LIST.

ATTACHED IS THIS FACILITY'S WRITTEN APPLICATION FORM. AS SOON AS YOU SUBSTANTIALLY COMPLETE AND RETURN THIS FORM TO THE FACILITY, YOUR NAME WILL BE PLACED ON OUR WAITING LIST FOR ADMISSION TO THE FACILITY. IT CAN ONLY BE ADDED TO OUR OFFICAL WAITING LIST AFTER WE HAVE RECEIVED THE SUBSTANTIALLY COMPLETED APPLICATION FORM.

DATE APPLICATION RECEIVED AT WEST HARTFORD HEALTH & REHAB _____

ADMISSION APPLICATION

I. VITAL STATISTICS

Resident Name : _____ Nickname : _____
Home Address : _____ Phone : _____
Present Location : _____ If hospital date of admit : _____
Describe Current Living Arrangements : _____
Date of Birth : _____ Birthplace : _____ Race: _____ Language : _____
Marital Status : _____ Religion : _____ Church : _____ US Citizen : _____
Former Occupation : _____ Education level : _____
Hospital Preference : _____ Community Physician : _____ Phone : _____
Pharmacy Preference : _____ Funeral Home Preference : _____
Have arrangements been made : _____ Do you have a prepaid funeral account : _____

II. RESPONSIBLE PARTIES

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

EMERGENCY CONTACT:

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

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

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

III. MISCELLANEOUS

Has placement been discussed with applicant : _____ Will prior living arrangements be available : _____
Type of stay REHAB _____ LONG TERM CARE _____ RESPITE _____ HOSPICE _____
Have any HOME CARE services been used in the past : _____ If yes, name of agency : _____
Does applicant have an ADVANCE DIRECTIVE : _____ If yes, explain : _____
Name of Power of Attorney, Health Care Agent, and /or Conservator : _____
Have arrangements been made to be an ORGAN DONOR : _____
Was applicant or spouse in military service : _____ If yes, which branch : _____

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
Medicare D Plan: _____ ID #: _____
Medicaid (Title 19 #) _____ Case Worker(if pending) _____ Phone : _____
Medical Insurance Company : _____ Policy ID # _____ Phone : _____
Other Medical Insurance _____ Policy ID # _____ Phone : _____
Life Insurance Company : _____ Surrender Value : \$ _____ Phone : _____
Does applicant own a Partnership-Approved Long Term Care Insurance Policy : _____
Other Long Term Care Insurance : _____ If yes, name of company : _____

Current Monthly Income :

Social Security : \$ _____ Where is this mailed : _____
Pension : \$ _____ Where is this mailed : _____
VA Benefits : \$ _____ Where is this mailed : _____
SSI : \$ _____ Where is this mailed : _____

Cash Assets:

BANK ACCOUNT # TYPE AMOUNT

- 1. _____
- 2. _____
- 3. _____

Certificate of Deposit : \$ _____ IRA : \$ _____ Annuities : \$ _____ Dividends : _____

Other Income : \$ _____
Does the applicant have a trust : _____ If yes, please explain : _____

Real Estate: Does applicant own any property : _____ Name on Deed : _____

Type & Location : _____

Estimate Value : \$ _____ Payable on mortgage : \$ _____

Has there been any sale/transfer of property/assets (liquid/non-liquid) within the last 60 months? _____

If yes, please specify amount & to whom. _____

Where has the applicant been in the last 60 days : _____

Has applicant been in another nursing facility within the past year : _____ If yes, where and when: _____

How will the stay be financed : (circle one)

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

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

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 **West Hartford Health & Rehabilitation Center** 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 _____