



**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 _____.

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 SOCIAL SERVICES, 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 RESIDENTS 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 LEVEL 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 DO NOT REQUIRE A SECURITY DEPOSIT. THE FACILITY REQUIRES PAYMENT OF THE TOTAL PER DIEM RATE FOR THE FIRST MONTH'S CARE AT THE TIME OF ADMISSION (OR A PRORATED AMOUNT FOR A PARTIAL MONTH) 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 AND YOU WILL NOT RECEIVE A BILL FROM US FOR CARE AND SERVICES COVERED BY THE MEDICARE PROGRAM. 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 SOCIAL SERVICES, WE DO NOT REQUIRE A DEPOSIT PRIOR TO ADMISSION. YOU WILL BE BILLED FOR CARE AND SERVICES PROVIDED EACH MONTH, AND ANY ACCRUED ANCILLARY 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 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 _____

Financial Disclosure

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

Resident Name: _____
 Social Security #: _____ Medicare #: _____
 Health Ins. #: _____ Medicare D#: _____
 Medicaid #: _____ Pending as of _____
 DSS Case Worker: _____ Phone #: _____
 Other Medical Insurance: _____ Policy ID#: _____
 Life Insurance Company: _____ Surrender Value: \$ _____
 Does applicant own a partnership-approved long term care insurance policy? _____
 Other long term care insurance: _____ 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? _____
 CDs: \$ _____ IRAs: \$ _____
 Annuities: \$ _____ Dividends: \$ _____
 Other Income: \$ _____ Stocks/Bonds: \$ _____
 Does Applicant have a Trust/receive yes no If yes, explain: _____
 income from a trust/or have interest in a trust? (Copy of trust instrument) _____

Cash Asset	Bank	Account #	Type	Amount

Real Estate

Does the applicant own any property? yes no If yes, was this the applicant's home prior to entering facility? yes no
 Does anyone else other than applicant live in this property? yes no
 Does anyone have life use of any real estate(ownership in full or part, for your lifetime or right to occupy for your lifetime yes no
 Type & Location: _____
 Names on deed: _____
 Estimated value: \$ _____ Payable on mortgage: \$ _____
 Has there been any sale or transfer of property/assets (liquid/non-liquid) within the past 60 months? yes no
 If yes, please specify amount & to whom: _____
 Was applicant and/or spouse a member of the US Armed Forces? yes no Branch: _____
 Where has the applicant been within the past 60 days: _____
 Has applicant been in another nursing home within past year? yes no If yes, where and when: _____
 If applicant is unable to handle their financial affairs, who can outstanding bills be sent for payment (person managing finances)?
 Name: _____ Phone: _____
 Address: _____
 Relationship to applicant: _____

Signature of Person Completing Application/Relationship to Applicant _____

Date _____

Medical Data

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

Resident Name: _____
Current Physician _____ Will physician be following? yes no
Current Diagnosis _____
Past Medical History _____
Medications _____

Nursing Needs

Indicate all that apply

Ambulation	Continance	Feeding	Bathing
<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	Dressing
<input type="checkbox"/> Bedbound	<input type="checkbox"/> Texas Catheter	<input type="checkbox"/> Gastric	<input type="checkbox"/> Independent
<input type="checkbox"/> Transfers	<input type="checkbox"/> Sup. Pub. Cath.	<input type="checkbox"/> J-tube	<input type="checkbox"/> With Assist
<input type="checkbox"/> Ind.	<input type="checkbox"/> Ostomy (type) _____	Rate	<input type="checkbox"/> Total Care
Assist of		Solution	
<input type="checkbox"/> 1 <input type="checkbox"/> 2		<input type="checkbox"/> Special Diet _____	

Adaptive Equipment: (type) _____

Mental Status	Behavior	Miscellaneous
<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	<input type="checkbox"/> Hearing Impaired _____
<input type="checkbox"/> Confused	<input type="checkbox"/> Belligerent	<input type="checkbox"/> Speech Impaired _____
<input type="checkbox"/> Non Responsive	<input type="checkbox"/> Noisy	<input type="checkbox"/> Vision Impaired _____
<input type="checkbox"/> Oriented	<input type="checkbox"/> Needs Restraints (type)	<input type="checkbox"/> Dentures _____
<input type="checkbox"/> Disoriented	<input type="checkbox"/> Wanders	<input type="checkbox"/> Allergies _____
	<input type="checkbox"/> Combative	<input type="checkbox"/> Skin:
	Smoker	<input type="checkbox"/> Intact _____
		<input type="checkbox"/> Reddened _____
		<input type="checkbox"/> Open Area _____
		<input type="checkbox"/> Size _____
Therapies Received: _____		<input type="checkbox"/> Oxygen (Litres) _____
Therapies Needed: <input type="checkbox"/> P.T. <input type="checkbox"/> O.T. <input type="checkbox"/> Speech		

Treatments: (Chemotherapy/Radiation, Other) _____

Other Pertinent Medical Information: (Infections/Drainage Tubes, Other) _____