# 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 theapplicant 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 REOUIREMENTS

**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_____

West Hartford
Health & Rehabilitation Center

# Admission Application

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

Resident Name: _____

Home address: _____

_____

Phone #: _____

Present location: _____

If hospital, date of admit: _____

Current living arrangements: _____

Location for the past 5 years (list all addresses):

_____

_____

_____

_____

_____

Date of birth: _____

Birthplace: _____

Marital status: _____

Religion _____

Former occupation: _____

Community physician: _____

Hospital preference: _____

Pharmacy preference: _____

Funeral home preference: _____

Prepaid funeral account? ☐ yes ☐ no

Have arrangements been made? ☐ yes ☐ no

Has placement been discussed with applicant? ☐ yes ☐ no

Will prior living accommodations be available after placement to facility? □ yes □ no

Have any HOME CARE services been used in the past? ☐ yes ☐ no Agency? _____

How does applicant plan to pay for cost of care? **Medicare| Insurance| LTC Insurance | Private Funds| Insurance Other| Medicaid**

Does applicant have an ADVANCE DIRECTIVE? ☐ yes ☐ no POWER OF ATTORNEY □yes □ no

Have arrangements been made to be an ORGAN DONOR? ☐ yes ☐ no

## Emergency Contact

Are you currently employed? □ yes □ no If yes, name of employer: _____

LIVING WILL □ yes □ no _____

Relationship: _____

Address: _____

Phone # (Home): _____

Phone # (Work): _____

Name: _____

Relationship: _____

Address: _____

Phone # (Home): _____

Phone # (Work): _____

**Contact 2**

Name: _____

Relationship: _____

Address: _____

Phone # (Home): _____

Phone # (Work): _____

**Contact 4**

Name: _____

Relationship: _____

Address: _____

Phone # (Home): _____

Phone # (Work): _____

## Type of Stay

☐ **REHAB** ☐ **HOSPICE** ☐ **RESPITE** ☐ **LONG TERM CARE**

□ Actively Seeking Placement
□ Future Placement

**We will need copies of the following:**

(copies can be made if desired)

- **MEDICAID Card (T-19)**
- **MEDICARE A/B and D Cards**
- **Insurance Cards – Health/LTC/Supplemental**
- **Living Will / Health Care Agent**
- **Power of Attorney & Conservatorship Documents**

**Thank you for taking the time to complete this application. Please tell us how you heard about this facility:**

_____

# 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 income from a trust/or have interest in a trust? (Copy of trust instrument) □yes □ no If yes, explain: _____

| 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

☐ Independent
☐ With Assist
☐ Walker
☐ Cane
☐ Wheelchair
☐ Bedbound
☐ Transfers
☐ Ind.
Assist of
☐ 1 ☐ 2

### Continence

☐ Continent
☐ Incontinent
☐ Bowel
☐ Bladder
☐ Foley Catheter
☐ Texas Catheter
☐ Sup. Pub. Cath.
☐ Ostomy (type) _____

### Feeding

☐ Independent
☐ With Assist
☐ Total Assist
☐ Feeding Tube
☐ NG
☐ Gastric
☐ J-tube
Rate
Solution
☐ Special Diet _____

### Bathing

☐ Independent
☐ With Assist
☐ Total Care

### Dressing

☐ Independent
☐ With Assist
☐ Total Care

Adaptive Equipment: (type) _____

### Mental Status

☐ Alert
☐ Understands
☐ Forgetful
☐ Confused
☐ Non Responsive
☐ Oriented
☐ Disoriented

### Behavior

☐ Cooperative
☐ Depressed
☐ Withdrawn
☐ Belligerent
☐ Noisy
☐ Needs Restraints (type)
☐ Wanders
☐ Combative
Smoker

### Miscellaneous

Weight _____
Height _____
☐ Hearing Impaired _____
☐ Speech Impaired _____
☐ Vision Impaired _____
☐ Dentures _____
☐ Allergies _____
☐ Skin:
☐ Intact _____
☐ Reddened _____
☐ Open Area _____
☐ Size _____
☐ Oxygen (Litres) _____

Therapies Received: _____

Therapies Needed: ☐ P.T. ☐ O.T ☐ Speech

Treatments: (Chemotherapy/Radiation, Other) _____

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