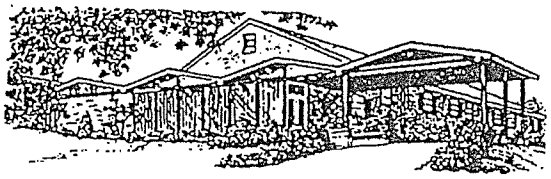
ADMISSION APPLICATION



Bel-Air Manor
Nursing & Rehabilitation Center

256 New Britain Avenue • Newington, CT 06111
Tel. (860) 666-5689 Fax (860) 666-7046

RYDERS HEALTH MANAGEMENT

CHARTING YOUR COURSE TO HEALTH

Joint Commission on Accreditation of Healthcare Organizations

"There is a destiny that makes us brothers
None goes his way alone:
All that we send into the lives of others
Comes back into our own."

Edwin Markham

REV. JUNE 2002

Admissions and Discharge Planning/ Waiting List/ Volume II

SEQUENTIAL# _____

Only Social Service Department is Authorized to Document-Date Received _____

APPLICATION FOR ADMISSION (please print clearly)

NAME _____ PREFERS TO BE CALLED _____

ADDRESS _____ CITY/STATE _____

BIRTH DATE _____ AGE _____ BIRTHPLACE _____ PHONE# _____

SEX _____ MARTIAL STATUS _____ NAME OF SPOUSE _____ MOTHERS MAIDEN NAME _____

MEDICARE # _____ MANAGED MEDICARE _____ SUPPLEMENT/PART B _____

OTHER INSURANCE _____ POLICY# _____

SOCIAL SECURITY# _____

REGISTERED VOTER? _____ WHERE _____ RELIGIOUS AFFILIATION _____

EDUCATION _____ FORMER OCCUPATION _____

FORMER EMPLOYER _____ DATE OF RETIREMENT _____

PHYSICIAN _____ VETERAN? _____ SPOUSE OF VETERAN _____

NAME OF FUNERAL HOME DESIRED _____ CITY _____ PHONE _____

LIST NAME AND LOCATION OF CHILDREN: _____

_____

_____

NUMBER OF GRANDCHILDREN: _____ GREAT GRANDCHILDREN _____

LIST BROTHERS, SISTERS, FRIENDS WHO ARE INVOLVED WITH INDIVIDUAL _____

_____

_____

INDIVIDUAL'S FORMER LIVING ARRANGEMENTS IN DETAIL ☐ ALONE ☐ w/HOME CARE ☐ w/SPOUSE ☐ w/FAMILY ☐ SPECIFY OTHER ____

DOES INDIVIDUAL HAVE STRONG RELIGIOUS BELIEFS? _____

IS THERE A HISTORY OF ALCOHOL OR DRUG DEPENDENCE? _____

HOW IS INDIVIDUAL COPING WITH CURRENT ILLNESS? _____

ARE THERE EMOTIONAL PROBLEMS (DEPRESSION, ANGER, MOOD CHANGE?) _____

LOSS OF LOVED ONES DURING THE PAST YEAR? _____

HOW DOES INDIVIDUAL FEEL ABOUT PLACEMENT?(acceptance, denial, anger, indifferent, unaware) _____

ARE THERE CURRENT PLANS FOR DISCHARGE FROM THIS FACILITY? _____

MEDICAL HISTORY

PRIMARY DIAGNOSIS _____

IS INDIVIDUAL AWARE OF HEALTH STATUS? ☐ YES ☐ NO PREVIOUS NURSING HOME ADMISSIONS _____

PREVIOUS HOSPITALIZATIONS _____ PSYCHIATRIC HOSPITALIZATIONS _____

IS INDIVIDUAL A HOSPICE PATIENT? _____ WHERE _____

ANTIPSYCHOTIC MEDICATION _____ ANTIDEPRESSANT _____ ANTIANXIETY _____

DRUG ALLERGIES _____

MEDICATIONS _____

CHEMOTHERAPY MEDICATION _____

OPERATIONS _____

PRESENT LOCATION OF APPLICANT _____ HOW LONG AT PRESENT LOCATION _____

REASON FOR PLACEMENT _____

INFORMATION PERTAINING TO INDIVIDUAL'S PERSONALITY & LIFESTYLE:

RECENT ACTIVITIES _____

VOLUNTEER ACTIVITIES _____

INTERESTS/HOBBIES _____

SPECIAL TALENTS _____

FAVORITE TOPIC OF CONVERSATION ☐ FAMILY ☐ GRANDCHILDREN ☐ SPORTS ☐ PAST EVENTS ☐ SPECIFY OTHERS _____

_____

PERSON RESPONSIBLE FOR APPLICANT'S ACCOUNT

NAME _____

ADDRESS _____ CITY/STATE _____ ZIP _____

HOME PHONE _____ BUSINESS PHONE _____

OCCUPATION _____ PLACE OF BUSINESS _____

RELATIONSHIP TO APPLICANT _____ P.O.A. OR CONSERVATORSHIP _____

PLEASE LIST TWO OTHERS TO NOTIFY IN EVENT OF EMERGENCY, OTHER THAN RESPONSIBLE PARTY.

NAME _____

ADDRESS _____

HOME PHONE _____ BUSINESS PHONE _____

NAME _____ RELATIONSHIP TO APPLICANT _____

ADDRESS _____

HOME PHONE _____ BUSINESS PHONE _____

PERSON COMPLETING THIS FORM _____ RELATIONSHIP TO APPLICANT _____

THIS SECTION TO BE COMPLETED BY SOCIAL SERVICE DEPARTMENT: LEVEL OF CARE _____

Services	Yes	No	Services	Yes	No
Laundry:Home			Is Responsible Person Fully Aware of Per Diem Rate?		
Laundry In House					
Tonsorial Services, Haircut and/or			Did Family Participate In Admission		
Of Full Discretion of Head Nurse			Will Family Participate In Discharge Plans?		
Manicurist/PRN			May Our Therapeutic Recreation Department Contact You For Minimal Volunteer Services For Major Functions? Your Volunteer Service and/or Talent Is Always Welcome		
Responsible Person Fully Aware Of					
Pays Discharge Notice Per Signed					
Admission Agreement					

CODE STATUS
☐ RESUSCITATE LIVING WILL
☐ DNR

CURRENT FUNCTIONING

MENTAL STATUS:

☐ ALERT ☐ CONFUSED ☐ ORIENTED ☐ DISORIENTED ☐ COMBATIVE

NURSING INFORMATION

VITAL SIGNS: T P R BP

Ambulation	1. Independent w/wo assistive device 2. Walks with supervision 3. Walk with continuous physical support 4. Bed to chair (Total Help) 5. Bedfast	COMMENTS
Transfer	1. No assistance 2. Equipment only 3 Supervision only 4. Requires Transfer w/wo equipment 5. Bedfast	
Bladder	1. Continent 2. Rarely e.g. hs. 3. Occasional-once/week or less 4. Frequent-up to once a day 5. Total Incontinence 6. Catheter-indwelling	
Bowel Control	1. Continent 2. Rarely 3. Frequent-once a week or more 4. Total Incontinence 5. Ostomy	
Bathing	1. No assistance 2. Supervision only 3. Assistance in shower/tub 4. Is bathed in shower/tub 5. Is bathed-bath procedure	
Dressing	1. Dresses self 2. Minor assistance 3. Partial help, completes 1/2 dressing 4. Has to be dressed	
Feeding	1. No assistance 2. Minor assistance needs tray set up only 3. Help in feeding encouraged 4. Is fed	☐ Dentures U or L or P

SENSORY/LANGUAGE IMPAIRMENTS

Sight	1. Good 2. Vision adequate-Unable to read line print 3. Vision limited-Gross object differentiation 4. Blind 5. Other	
Hearing	1. Good 2. Hearing slightly impaired 3. Limited hearing (eg.-must speak loudly) 4. Virtually completely deaf	☐ Hearing Aid R or L
Speech	1. Speaks clearly w/other of same language 2. Some defect-usually gets message across 3. Unable to speak clearly or not at all	

ALLERGIES

REHAB PLAN/THERAPEUTIC GOAL: ☐ GOOD ☐ FAIR ☐ POOR ☐ INDETERMINATE

SKIN INTEGRITY

DECUBITUS & STAGE

HEIGHT _____WEIGHT _____

FINANCIAL INFORMATION

APPLICANT'S NET WORTH

_____ 0 to $16,500
_____ $16,501 to $50,000
_____ $50,001 to $100,000
_____ $100,001 to $250,000
_____ Over $250,000

MEDICARE# _____ Part A ___yes ____no Part B _____yes _____no
MEDICAID# _____ BC/BS# _____
PENDING ☐ yes ☐ no Name of Case Worker _____ Phone _____
Other Medical Insurance _____ Policy# _____
Veteran ____ ☐ yes ____ ☐ no Spouse of Veteran _____ ☐ yes ____ ☐ no

RESIDENTS INCOME SOURCE

Social Security	$ _____	Monthly Benefits Number _____
VA Benefits	$ _____	Monthly Benefits Number _____
Pension (company)	$ _____	Monthly Benefits Number _____
SSI	$ _____	Monthly Benefits Number _____
CD's	$ _____	Yearly Source _____
Annuities	$ _____	Yearly Source _____
Dividends	$ _____	Yearly Source _____
Interest	$ _____	Yearly Source _____

Do you receive income from or have an interest in any trusts? ____yes ____no
If yes, please provide a copy of the trust instrument.

Within the past thirty (30) months, have you created any trusts or placed funds or any other assets in a trust that already exists?_____yes _____no

BANK ACCOUNTS

NAME OF BANK	NAME ON ACCT.	TYPE OF ACCT.	BALANCE

REAL ESTATE

Type of Real Estate	Where Located	Ownership	Estimated

Stocks and Bonds. (Please describe and give approximate value)

Life Insurance. (Please describe and give current balance)

Other. (Please describe fully and specify balance)

Does the applicant own an approved "Connecticut Partnership for Long-Term Care" insurance policy?

[ ] Yes [ ] No

Nota Bene - You can identify a policy as Partnership-approved by checking to see if the following statement is on the face page of the policy: **"This policy has been precertified under the Connecticut Partnership for Long-Term Care and provides Medicaid Asset Protection."** Many, but not all, of the policies also include the Partnership logo.

Does the applicant have a "life use" of any real estate (any ownership interest, in full or in part, for his or her lifetime, or the right to occupy property for his or her lifetime?)

[ ] Yes [ ] No

If yes please describe:

TRANSFER OF ASSETS

Within thirty-six (36) months prior to the date of this application, has the applicant or the applicants spouse given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind for less than fair value market value? If so, please describe fully all such gifts or transfers in excess of $1,000, including the asset transferred, names, addresses and relationship to the person to whom the gift or transfer was made, and the value of the gift or transfer.

_____

_____

_____

_____

_____

_____

Within sixty (60) months prior to the date of this application, has the applicant or the applicant's spouse created any trusts or placed funds or any other assets in a trust that already existed?

[ ] YES [ ] NO

If yes, please describe and provide a copy to the trust instrument.

_____

_____

I certify that I have fully investigated the applicant's current income and assets and any gifts or transfers for less than fair market value in excess of $1,000 and any trusts created or transfers of assets to any trust that the applicant or his or her spouse has made.

_____ _____

(Responsible Party) (Date)

Part 4. Applicant Income

	Annual Income Applicant
Social Security	$
VA Benefits	
Pension	
SSI	
Interest from Savings, CD's Other	
Annuities	
Dividends	
Alimony	
Other	
Total Annual Income	$

Part 5. Applicant Financial Information

Assets	Value	
Cash	$	
Gov. Securities		$0
Stocks/Bonds	$	
Primary Residence	$	
Wholly Owned R E	$	
Partially Owned R E	$	
Retirements Accounts	$	
Life Insurance	$	
Personal Property	$	
Total Assets		

Part 6. Transfer of Assets

Within 60 months (5 years) has the applicant or applicant's spouse given away assets of any kind (cash, Securities, real estate etc). If so describe fully all such transfers in excess of $1,000 in value include names addresses and relationship of whom the gift or transfer was made to.

Financial Information Detail

Bank Accounts	Account Names	Type	Balance
Government Securities	In Name Of/Bearer	Type	Amount
Stocks & Bonds	Broker		Amount
Primary Residence	Owner's		Value
Address Mortgage	Bank/Mortgage Co.		Amount
Other Real Estate	Owner's		Value
Location Retirement Accounts	Bank/Broker		Value
Life Insurance	Company		Cash Value
Other Personal Property	Type		Value

I certify that I have fully investigated the applicants current income and assets and any gifts or transfers for less than market value in excess of $1,000 and any trusts created or transfers of assets to any trusts that the applicant or his or her spouse has made.

_____ _____

Responsible Party Date

PERSONAL FINANCIAL INFORMATION

Facility

As of Date Completed By

Part 1. Personal Information

Name
Address
Residential Telephone
Residential Fax

Social Security
Medicare #
Medicaid #
Anthem #
Other Insurance Co.

Long Term Care Insurance
Carrier
Policy #
Copy Secured Yes No

Veteran Yes No
Spouse of Veteran

Part 2. General Information

Are you a Beneficiary of any trusts? Yes No

Amount of Trust
Type of Assets in Trust
Name & Address of Trustee

Have you ever declared bankruptcy? Yes No

Income Tax returns current Yes No
Are any tax returns under audit? Yes No

If yes, to any of the above, please provide details.

Part 3. Responsible Party Information

Responsible Party
Relationship to Resident Spouse Other
Address
Social Security #
Residential Telephone
Residential Fax