

Westview

HEALTH CARE CENTER

Excellent Care

Outstanding Staff

Distinct Reputation

APPLICATION FOR ADMISSION



OFFICE OF ADMISSIONS

150 Ware Road, Dayville, Connecticut 06241

860-774-8574 • 860-779-5969 fax

www.westviewhcc.com



I. GENERAL INFORMATION

Name of Applicant _____

Home Address _____

_____ Home Phone # (____) _____

Date of Birth____/____/____ Marital Status_____ Sex_____

Religion/Parish:_____ Birthplace: _____

Responsible Party for Financial Decisions

Are you a U.S. Citizen? Yes No

Name _____ Telephone: Days_____

Address _____ Evenings_____

Relationship _____ ___POA ___Conservator of Person

Applicant's Attorney _____

(if applicable) (name) (address) (phone)

Person to contact in case of emergency (medical decisions)

Name _____ Telephone: Days_____

Address _____ Evenings_____

Relationship _____ ___POA ___Conservator of Person

Alternate contact person

Name _____ Telephone: Days_____

Evenings_____

If applicant is in a medical facility at present, complete the following:

Name of Facility: _____ Date of Admission____/____/____

Address of Facility: _____

II. MEDICAL INFORMATION

Name of Attending Physician: _____

Address: _____

Primary Diagnosis: _____

Past Medical History: _____

If applicant is not presently in a medical facility, please list medications.

<u>Medication</u>	<u>When Taken</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the applicant been receiving any medical care from a related or non-related party? YES NO

Type of Placement Applicant is Seeking

_____ Long term placement _____ Short term placement for rehabilitation

_____ Respite care - for respite care please indicate
time frame requested: ____/____/____ to ____/____/____

Living will or Advance Directive? YES NO

III. FINANCIAL INFORMATION (Please be prepared to bring copies 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

<u>Name of Company</u>	<u>Identification #</u>	<u>Type of Insurance</u>
_____	_____	_____
_____	_____	_____

Do you own a Partnership-Approved Long-Term Care Insurance Policy? (This policy has been precertified 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 \$ _____

Income - Applicant, and spouse if applicable

Please list all income including but not limited to:
Social Security, Pensions, VA Benefits, Workman's Compensation, Annuities, Rental Income.

<u>Source</u>	<u>Amount</u>	<u>Payable to Whom</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Cash Assets

Please list all assets including but not limited to:
Savings Accounts, Checking Accounts, Stocks, Bonds, C.D.'s, Trusts, Annuities, etc...

Name of Institution	Account #	Present Balance	Largest Balance in past 36 months

Real Estate

Does applicant own any real estate? YES NO

Description of Property	Approximate Value	Name(s) on Deed

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?

Item Transferred	Value	To Whom	Date

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

_____ (Responsible Party)

_____ Date

_____ Date