Application for Admission

Please Print

Applicant's Contact Information

Name:____
(First) (Middle) (Last) (Maiden)

Address:____
(Street) (City) (State) (Zip code)

How Long?____________________ Telephone #:__________________________
(Yrs./mths)

Email:______________________________________

Date of Birth:________________ Age:__________ Sex: (M)_____ (F)_______

Marital Status: Divorced ________Single______ Married__________ Widowed_________

Name of Spouse:____________________

Social Security #:____________________ Medicare #:______________________

Other Insurance:____________________ Medicare Part D:____________________

Medicaid #:________________________

Has the applicant applied for Title XIX/Medicaid assistance? Yes______ No________

If so, what programs are they currently on:__________________________________

Please list your worker's name and telephone number: __________________________

Does the applicant have a living will? Yes____ No_____

Does the applicant have a health care agent? Yes____ No_____

Power of Attorney? Yes____ No____ Conservator? Yes____ No_____

If yes, contact information:____

(Please attach a copy of each)

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Nearest Relative/Responsible Party

Name:______________________________ Relationship:______________________

Address:____

Work Telephone:____________________ Home Telephone:____________________

Email Address:______________________

Contact information in case of an emergency:

1. Name______________________
   Relationship______________________
   Address______________________
   ____
   Telephone______________________
   Email: ______________________

2. Name______________________
   Relationship ______________________
   Address ______________________
   ____
   Telephone______________________
   Email: ______________________

Family Information:

Children	Name	Address	Work & Home tel #
1.			
2.			
3.			
4.			

Military Service:

Did the applicant serve in the military? Yes ______ No______

Did your spouse serve in the military? Yes ______ No______

If yes, please list branch of service and serial #______________________

Has the applicant applied for Veterans Benefits? Yes ____ No _____

Health History:

Primary Care Physician's Name ____________________

Address ____________________

Telephone ____________________ Fax ____________________

Specialist Physician's Name ____________________

Address ____________________

Telephone ____________________ Fax ____________________

Dentist's Name ____________________

Address ____________________

Telephone ____________________ Fax ____________________

Has the applicant ever been a resident of any other home or institution? Yes______ No_____
If *"yes"*, give the name and address ____________________

Has the applicant been hospitalized within the last 12 months? Yes_____ No______
If *"yes"*, when and why? ____________________

Is applicant being followed by a psychiatrist? Yes______ No______
(If yes, please include the following)

Name ____________________

Address ____________________

Telephone ____________________ Fax ____________________

Activities of Daily Living:

Ambulation:	Independent_____	Walker ______	Cane ______
Ability to bathe self:	Independent_____	Some Assist _____	Other ______
Ability to dress self:	Independent_____	Some Assist _____	Other ______
Ability to feed self:	Independent_____	Some Assist _____	
Bladder Continence	Always______	Occasional ______	Never______
Bowel Continence	Always______	Occasional ______	Never______

Hearing:	Normal _____	Impaired ______	Deaf______	Hearing aid L______ R______
Speech:	Normal _____	Impaired ______		
Vision:	Normal _____	Impaired ______	Eyeglasses______	
Orientation:	Lucid _____	Forgetful ______	Confused at Times______	

Do you Smoke? Yes ____ No____

Allergies: Yes _____ No _____ If yes, please list ________________________________

Please list all medications:

Name:	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		

Medication Allergies: Yes _____ No _____ If yes, please list ______________________________

Applicants Financial Information

Income:

Social Security	$____________/mo.	Source____________
Pension	$____________/mo.	Source____________
Annuity/Mutual	$____________/mo.	Source____________
Interest/Dividends	$____________/mo.	Source____________
Veteran's Benefits	$____________/mo.	Source____________
Trust	$____________/mo.	If *"yes"*, please provide a copy
Other	$____________/mo.	Source____________

Assets:

	Individual	Joint	None	Value
Own Home	______	______	______	$____________
Other Property	______	______	______	$____________
Stocks/Bonds	______	______	______	$____________
Mutual Funds	______	______	______	$____________
IRA's/Keoughs	______	______	______	$____________
Life Insurance	______	______	______	$____________
Funeral Arrangements	______	______	______	$____________
Other	______	______	______	$____________

In the past 24 months, has the applicant sold, given away [as gifts] or transferred assets of any kind [i.e. motor vehicle, stocks, bonds, cash] for less than fair market value?

Yes_____ No_____

If *"yes"*, please list all such transactions in excess of $1,000____________

Please list all Bank Accounts:

Include certificates of Deposit

Owner(s) of Account ____________ Present Balance $____________

Bank Name____________ Account Number ____________

Address ____________

Owner(s) of Account____________ Present Balance $____________

Bank Name____________ Account Number ____________

Address____________

Owner(s) of Account____________ Present Balance $____________

Bank Name____________ Account Number ____________

Address ____________

Do you give Parsonage Cottage permission to use your photos in marketing materials?

Yes_________ No________

Education & Activities

Highest level of education completed ______________

Former Occupation________________________

Membership in Organizations ____

Leisure Actilvities/Hobbies____

Special Interests and Skills____

Pre Need Burial Arrangements:

Yes _____ No _____

Funeral Parlor Name:____

Address **Telephone #**

____

Applicant's Signature/Responsible Party **Print Name** **Date**

*All applicants may be subject to a background check

COMPLIANCE INFORMATION (OPTIONAL)

The following information is needed for compliance with government selection requirement and for Equal Opportunity Housing reports. It will be detached when your application is filed and the information on it will not be considered in the selection process.

Sex: Male______ Female_______

Describe yourself in terms of one of the following groups:

___White (not of Hispanic origin) ___Black (not of Hispanic origin) _____Hispanic

___ Asian or Pacific Islander ___American Indian or Alaskan Native

AUTHORIZATION FOR RELEASE OF INFORMATION

RESIDENT'S NAME: ______________________________ DATE OF BIRTH: ___________________

I hereby authorize the release of all medical information, to Parsonage Cottage Senior Residence. This includes all health care professionals, hospitals, laboratory and diagnostic results. Please release all information which may be requested regarding my past or present condition and treatment rendered therefore.

I hereby authorize full disclosure between Parsonage Cottage Senior Residence and The Department of Social Services of the State of Connecticut, of all information pertinent to my admission and recertification process.

This release will remain in effect/valid during residency and expires upon discharge.

Applicant's Signature: ____ Date: _____________

Signature of Person Completing Form: ____
(If not the Applicant)

Relationship to Applicant: ____ Date: _____________

Conservator: ________ Power of Attorney: ______________

(If Conservator or Power of Attorney is checked, please attach the appropriate documentation.)

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RATES

Inclusive of all services:

- Market Rate: **$ 167.67 Daily**
  $ 5,100.00 Monthly

- Financial Assistance:

  Is available for qualifying individuals under the "Aid to the Aged, Blind and Disabled" program set by the Department of Social Services of CT.

SERVICES PROVIDED

Inclusive in the monthly rate:

- Three (3) meals and snacks serviced daily
- Weekly housekeeping
- Laundering of linen and towels
- 24-hour staff availability
- Assistance with bathing, dressing, personal laundry
- Storage, supervision, ordering and delivery of medication
- Sprinkler and smoke alarm in each room
- 24-hour emergency call system in each room and bath
- Free Cablevision (Family Cable)
- Recreation program
- Social Worker available