

**Personal/Financial Information**

**Primary Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Town \_\_\_\_\_ State \_\_\_\_\_ Work Phone \_\_\_\_\_

**Secondary Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Town \_\_\_\_\_ State \_\_\_\_\_ Work Phone \_\_\_\_\_

Veteran  Yes  No U.S. Citizen  Yes  No

**Financial Disclosure:** (All information supplied will remain confidential. Application cannot be processed without this information.)

Social Security Number \_\_\_\_\_ Medicare Number \_\_\_\_\_

Medicaid Number (Title 19) \_\_\_\_\_ Pending?  Yes  No

Medicaid Caseworker's Name \_\_\_\_\_ Phone \_\_\_\_\_

Managed Medicare, Commercial, Medicare Supplement \_\_\_\_\_ Policy No. \_\_\_\_\_

Does Applicant Own a Long Term Care Insurance Policy? \_\_\_\_\_

Name of Company \_\_\_\_\_ Is this a Partnership Approved Policy? \_\_\_\_\_

Established Monthly Income: Social Security \_\_\_\_\_ Other \_\_\_\_\_

Assets: negotiable securities, stocks, bonds \_\_\_\_\_

**Savings/Checking Accounts:**

Bank	Type of Account	Joint/Single	Balance

Properties: \_\_\_\_\_ Names on Deed: \_\_\_\_\_

Mortgage notes you hold on properties \_\_\_\_\_

Has there been a transfer of assets or monetary gifts within the last 60 months?  Yes  No

Be specific \_\_\_\_\_

Name \_\_\_\_\_ Phone No. (home) \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_ Phone No. (work) \_\_\_\_\_

Relationship \_\_\_\_\_

*Signature of person completing application* \_\_\_\_\_

# Admission Application

SOUTHINGTON



CARE CENTER

You have contacted this facility and indicated a desire to be considered for admission. Your name will be placed on our waiting list after you substantially complete and return this application.

**SMOKE FREE ENVIRONMENT**

**Southington Care Center  
Application for Admission**

**Vital Statistics**

Name \_\_\_\_\_ Telephone \_\_\_\_\_  
 Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 Date of Birth \_\_\_\_\_ Birthplace \_\_\_\_\_  
 Marital Status \_\_\_\_\_ Religion \_\_\_\_\_  
 Occupation (Current or Former) \_\_\_\_\_

Type of Placement Being Sought (*Please Check*):

- Short Term Rehab     Hospice Care     Respite Care     Long Term Care

**Medical Information**

Present Location \_\_\_\_\_  
 If Hospital/Health Facility, Date of Admission \_\_\_\_\_  
 Admitting Diagnosis \_\_\_\_\_  
 Surgery (include dates) \_\_\_\_\_

Past Medical History \_\_\_\_\_

Allergies \_\_\_\_\_

Current Medications \_\_\_\_\_

**Skin Condition**

Surgical Site \_\_\_\_\_ Reddened Areas \_\_\_\_\_

Decubitus \_\_\_\_\_ Treatment \_\_\_\_\_

Diet \_\_\_\_\_ HT \_\_\_\_\_ WT \_\_\_\_\_

**Mental Status**

- Alert     Oriented     Confused     Disoriented     Forgetful

- Vague     Non-responsive     Depressed

**Behavior Patterns**

- Cooperative     Wanders     Paces     Combative     Verbally Abusive

- Resistive to Care     Easily Agitated     Other \_\_\_\_\_

Restraints     Waist     Vest     Pelvic

Restraints     Always     Daytime     Nighttime     As Needed     None

Current Therapies     PT     OT     Speech  
 Other \_\_\_\_\_

**Functional Data Summary**

	Independent	Minimal Assist (Supervise)	Maximum Assist (1-2 Person)	Unable	Independent
Bathing					
Dressing					
Toileting					
Eating					<input type="checkbox"/> G Tube <input type="checkbox"/> NG Tube
Transferring					<input type="checkbox"/> Hoyer Lift
Ambulating					

**Continence**

- Continent     Incontinent  
 If Incontinent:     Urine     Stool  
 Foley Catheter     Suprapubic Catheter     Texas Catheter (External Device)  
 St. Catheter     Colostomy     Ileo Conduit

**Mechanical Aids**

Oxygen/Liters \_\_\_\_\_

Pace Maker     Yes     No    Date Inserted \_\_\_\_\_

Prosthesis (Type): \_\_\_\_\_

**History of Psychiatric Problems or Disorders (Include Details and Dates of Hospitalization)**

\_\_\_\_\_  
 \_\_\_\_\_

**History of Alcohol or Substance Use? If Yes, Describe**

\_\_\_\_\_

Smoker     Yes     No

**Miscellaneous Information**

Primary Care Physician \_\_\_\_\_

Other Physician(s) \_\_\_\_\_

Advance Directives     Yes     No

If Yes, Please indicate:     POA     DPOA     HCA     Living Will     Organ Donor     Conservator

During the last 60 days, has there been a stay in a hospital or nursing facility? \_\_\_\_\_ If so, please indicate where and when stay took place. \_\_\_\_\_

Have Home Care Services been used in the past? \_\_\_\_\_

If so, please indicate which agency. \_\_\_\_\_

Funeral Home Preference: \_\_\_\_\_

Have arrangements been made? \_\_\_\_\_ Prepaid? \_\_\_\_\_