

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? _____