

**Primary Emergency Contact:**

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

Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_

**Secondary Contact:**

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

Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_ E-mail \_\_\_\_\_

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

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

Health Insurance Plan \_\_\_\_\_ Policy # \_\_\_\_\_

Medicare Supplement \_\_\_\_\_ Policy # \_\_\_\_\_

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

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

Copies of cards enclosed (back and front)  Yes  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 with dates and amounts: \_\_\_\_\_

\_\_\_\_\_

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

Address \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Phone Numbers: Home \_\_\_\_\_ Work \_\_\_\_\_

Send update letters to \_\_\_\_\_

*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**

45 Meriden Avenue • Southington, Connecticut 06489 • 860-621-9559

**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) \_\_\_\_\_  
 Veteran  Yes  No U.S. Citizen  Yes  No

**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
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

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? \_\_\_\_\_