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.

Please check off all the communities in which you are interested:

Skilled Nursing Communities
- Jerome Home
- Jefferson House
- Southington Care Center

Assisted Living Communities
- Arbor Rose
- Cedar Mountain Commons
- Mulberry Gardens of Southington
- The Orchards at Southington

SMOKE FREE ENVIRONMENT
Hartford HealthCare Senior Services  
Application for Admission

**Vital Statistics**

Name ____________________________________________________________________ Telephone________________________

Address ______________________________________________________________ City ___________________ State ______ Zip Code ________

Sex  M  F  Date of Birth________________________ Place of Birth________________________

Marital Status ____________________ Religion ____________________ Place of Worship________________________

Occupation (Current or Former) ____________________________________________

Type of Placement Being Sought (Please Check):

- Short Term Rehab  
- Hospice Care  
- Long Term Care  
- Assisted Living

**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  
- Pacs  
- Combative  
- Verbally Abusive  
- Resitive to Care  
- Easily Agitated  
- Other ____________________

Restraints

- Waist  
- Vest

Restraints

- Always  
- Daytime  
- Nighttime  
- As Needed  
- None
### Functional Data Summary

<table>
<thead>
<tr>
<th>Activity</th>
<th>Independent</th>
<th>Minimal Assist (Supervise)</th>
<th>Maximum Assist (1-2 Person)</th>
<th>Unable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dressing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Toileting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eating</td>
<td></td>
<td></td>
<td>____ G Tube</td>
<td></td>
</tr>
<tr>
<td>Transferring</td>
<td></td>
<td></td>
<td>____ NG Tube</td>
<td></td>
</tr>
<tr>
<td>Ambulating</td>
<td></td>
<td></td>
<td>____ Hoyer Lift</td>
<td></td>
</tr>
</tbody>
</table>

**Continence**
- [ ] Continent
- [ ] Incontinent
  - If Incontinent:
    - [ ] Urine
    - [ ] Stool
- [ ] Foley Catheter
- [ ] Suprapubic Catheter
- [ ] Texas Catheter (External Device)
- [ ] St. Catheter
- [ ] Colostomy
- [ ] Ileal 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** ____________________________ Address & Phone ____________________________

**Other Physician(s)** ____________________________ Address & Phone ____________________________

**Attorney** ____________________________ Address & Phone ____________________________

**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?**
- [ ] Yes
- [ ] No

If so, please indicate where and when stay took place.

__________________________________________________________________________________________________________

**Have Home Care Services been used in the past?**

__________________________________________________________________________________________________________

**Funeral Home Preference:** ____________________________ Address: ____________________________

**Have arrangements been made?**

- [ ] Yes
- [ ] No

Prepaid? ____________________________
Emergency Contact:

Primary Contact
Name_________________________________________ Relationship ________________________________
Address________________________________________ Home Phone ________________________________
City_________________________ State ______ Zip Code ________________
Work Phone _________________ Cell Phone____________________ E-mail____________________________

Secondary Contact
Name_________________________________________ Relationship ________________________________
Address________________________________________ Home Phone ________________________________
City_________________________ State ______ Zip Code ________________
Work Phone _________________ Cell Phone____________________ E-mail____________________________

Send update letters to __________________________________________________________

ATTACHED FINANCIAL DISCLOSURE FORM MUST ALSO BE COMPLETED.

(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? __________

Veteran (or spouse of a veteran) □ Yes □ No U.S. Citizen □ Yes □ No

Signature of person completing application ______________________________
Date of Completion ______________________________
Hartford HealthCare Senior Services
Applicant's Financial Disclosure

Applicant's Name: _______________________ Date: __________

The applicant and/or responsible party may be required to submit copies of all current accounts (checking, savings, money market, mortgage, etc.) upon completion of this form and at the time of admission.

<table>
<thead>
<tr>
<th>Applicant's Own income-list GROSS amount</th>
<th>Spouse's income-list GROSS amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Security</td>
<td>Social Security</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>$ ___________ /Mo</td>
</tr>
<tr>
<td>Pension</td>
<td>Pension</td>
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<tr>
<td>$ ___________ /Mo</td>
<td>$ ___________ /Mo</td>
</tr>
<tr>
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<td>Annuity</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>$ ___________ /Mo</td>
</tr>
<tr>
<td>Interest</td>
<td>Interest</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>$ ___________ /Mo</td>
</tr>
<tr>
<td>Dividends</td>
<td>Dividends</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>$ ___________ /Mo</td>
</tr>
<tr>
<td>Other</td>
<td>Other</td>
</tr>
<tr>
<td>$ ___________ /Mo</td>
<td>$ ___________ /Mo</td>
</tr>
</tbody>
</table>

Not applicable       ____

Does the applicant receive income from or have any interest in a trust? Yes____ No____

Does the applicant's spouse receive income from or have any interest in a trust? Yes____ No____

Will the money in this trust be available for the applicant's care? Yes____ No____

Does the applicant have a Long Term Care Insurance policy? Yes____ No____

Has the applicant ever applied for any other benefits (VA benefits, Pilot Program) that will potentially give additional income? Yes____ No____

If yes, please describe what benefits have been applied for and the date of application.

____________________________________________________________________________
____________________________________________________________________________

Applicant's Assets

(Note: If any asset is jointly held, please give name of joint owner. If married, list all assets owned by the applicant and his/her spouse, regardless of whether the assets are owned individually or jointly).

Properties

Address and approximate value: __________________________________________________

Names on Deed: ________________________________________________________________

Does the spouse live in the home? Yes____ No____

What is the amount of equity in the home: $ ________________________________

Mortgage notes held on the property: ____________________________________________
**Stocks and Bonds** - Please describe and give approximate value

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**Bank Accounts**

<table>
<thead>
<tr>
<th>Bank:</th>
<th>Type of account:</th>
<th>Single/joint with whom:</th>
<th>Balance:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

**Life Insurance** - List only those policies having a cash surrender value and give approximate surrender value.

______________________________________________________________________________

______________________________________________________________________________

**Annuities** - Has the applicant purchased or does the applicant receive income from any annuity? If yes, please describe. Please list specifics with each annuity (monthly payments and/or yearly payment).

______________________________________________________________________________

______________________________________________________________________________

**Transfer of Assets within 60 months (5 years)**

Within 60 months (5 years) prior to the date of this application, has the applicant or spouse given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind?

Yes____  No_____

If so, please describe fully all such gifts or transfers of $500 or more, including the asset transferred, date of transfer, names, addresses and relationship of the person to whom the gift was made and the value of the gift or transfer.

______________________________________________________________________________

______________________________________________________________________________

Within 60 months prior to the date of this application, has the applicant or spouse created a trust or placed funds or any other assets in a trust that already exists? Yes____  No_____

If so, please describe fully all existing or newly created trusts.

______________________________________________________________________________
If signed by the Applicant:
I hereby certify that this is a true and complete statement of my (and if applicable, my spouse’s) income and assets and any gifts or transfers in excess of $500 and any trusts created or transfers of any assets to any trust that I or my spouse have made.

__________________________________________
Applicant Signature Date

If signed by the Responsible Party:
I certify that I have investigated the applicant’s financial records and that this is a true and complete statement of the applicant’s income and assets and any gifts or transfers in excess of $500 and any trusts created or transfers of any assets to any trust that the applicant or his or her spouse has made.

__________________________________________
Person Acting for Applicant

__________________________________________
Print Name

__________________________________________
Title

__________________________________________
Date