

# Westview

HEALTH CARE CENTER

*Excellent Care*

*Outstanding Staff*

*Distinct Reputation*

## APPLICATION FOR ADMISSION



### OFFICE OF ADMISSIONS

150 Ware Road, Dayville, Connecticut 06241

860-774-8574 • 860-779-5969 fax

[www.westviewhcc.com](http://www.westviewhcc.com)



**I. GENERAL INFORMATION**

Name of Applicant \_\_\_\_\_

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

\_\_\_\_\_ Home Phone # (\_\_\_\_) \_\_\_\_\_

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Marital Status \_\_\_\_\_ Sex \_\_\_\_\_

Religion/Parish: \_\_\_\_\_ Birthplace: \_\_\_\_\_

**Responsible Party for Financial Decisions**

Are you a U.S. Citizen?  Yes  No

Name \_\_\_\_\_ Telephone: Days \_\_\_\_\_

Address \_\_\_\_\_ Evenings \_\_\_\_\_

\_\_\_\_\_

Relationship \_\_\_\_\_  POA  Conservator of Person

**Person to contact in case of emergency (medical decisions)**

Name \_\_\_\_\_ Telephone: Days \_\_\_\_\_

Address \_\_\_\_\_ Evenings \_\_\_\_\_

\_\_\_\_\_

Relationship \_\_\_\_\_  POA  Conservator of Person

**Alternate contact person**

Name \_\_\_\_\_ Telephone: Days \_\_\_\_\_

Evenings \_\_\_\_\_

**If applicant is in a medical facility at present, complete the following:**

Name of Facility: \_\_\_\_\_ Date of Admission \_\_\_\_/\_\_\_\_/\_\_\_\_

Address of Facility: \_\_\_\_\_

**II. MEDICAL INFORMATION**

Name of Attending Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Diagnosis: \_\_\_\_\_

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

\_\_\_\_\_

If applicant is not presently in a medical facility, please list medications.

<u>Medication</u>	<u>When Taken</u>	<u>Reason</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Type of Placement applicant is Seeking**

\_\_\_\_\_ Long term placement \_\_\_\_\_ Short term placement for rehabilitation  
\_\_\_\_\_ Respite care - for respite care please indicate  
time frame requested: \_\_\_\_/\_\_\_\_/\_\_\_\_ to \_\_\_\_/\_\_\_\_/\_\_\_\_

Living will or Advance Directive?  YES  NO

**III. FINANCIAL INFORMATION** (Please be prepared to bring copies of cards)

Social Security #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Medicare Co-Pay #: \_\_\_\_\_ Medicare Supplement #: \_\_\_\_\_

Medicaid (State Medical Assistance) #: \_\_\_\_\_

Does the applicant have an application pending for State Medical Assistance (Title 19)?

YES  NO If yes, please indicate: Date application submitted: \_\_\_\_/\_\_\_\_/\_\_\_\_

District Office: \_\_\_\_\_ Case Worker: \_\_\_\_\_

Is the applicant a Veteran?  YES  NO Spouse of a Veteran?  YES  NO

Is the applicant covered by any other medical or hospital insurance?  YES  NO

<u>Name of Company</u>	<u>Identification #</u>	<u>Type of Insurance</u>
_____	_____	_____
_____	_____	_____

Do you own a Partnership-Approved Long-Term Care Insurance Policy? (This policy has been precertified under the Connecticut Partnership for Long-Term Care and provides Medicaid Asset Protection)?

YES  NO If yes, with whom? \_\_\_\_\_

What is your current ID # \_\_\_\_\_

Does the applicant own life insurance?  YES  NO

If yes, Name of Company: \_\_\_\_\_

Cash Value \$ \_\_\_\_\_ Face Value \$ \_\_\_\_\_

Has an irrevocable burial account been established?  YES  NO

Name of Funeral Home: \_\_\_\_\_ Amount \$ \_\_\_\_\_

**Income - Applicant, and spouse if applicable**

Please list all income including but not limited to:  
Social Security, Pensions, VA Benefits, Workman's Compensation, Annuities, Rental Income.

<u>Source</u>	<u>Amount</u>	<u>Payable to Whom</u>
Supplemental	_____	_____
Security Income?	_____	_____
_____	_____	_____
_____	_____	_____

**Cash Assets**

Please list all assets including but not limited to:  
Savings Accounts, Checking Accounts, Stocks, Bonds, C.D.'s

Name of Institution	Account #	Present Balance	Largest Balance in past 36 months

**Real Estate**

Does applicant own any real estate?  YES  NO

Description of Property	Approximate Value	Name(s) on Deed

Are there any liens or mortgages against the property?  YES  NO

If so, in the amount of \$\_\_\_\_\_ payable to\_\_\_\_\_

**Transfer of assets**

Has the applicant transferred, sold, or given real estate, personal property, cash or any other assets in the past 60 months?

Item Transferred	Value	To Whom	Date

I certify that I have fully investigated the applicant's financial records and that this is a true and complete statement of the applicant's current income and assets and any gifts or transfers for less than fair market value in excess of \$1,000 that the applicant has made within the sixty (60) months prior to the date of this application.

\_\_\_\_\_ Applicant

\_\_\_\_\_ (Responsible Party)

\_\_\_\_\_ Date

\_\_\_\_\_ Date