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

WESTVIEW
HEALTH CARE CENTER

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.

Medication	When Taken	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Has the applicant been receiving any medical care from a related or non-related party? ❑ YES ❑ NO

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

Name of Company	Identification #	Type of Insurance

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.

Source	Amount	Payable to Whom
Supplemental		
Security Income?		

Cash Assets

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

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_____

Is anyone other than the applicant living in the home? ❑ YES ❑ NO

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