Resident's Name

/ /20
Date

APPLICATION FOR ADMISSION

APPLICANT

Name: ______ Date of Birth: ______

Present Address: ______ Own or Rent: ______

______ Marital Status: ______

Telephone Number: ______ Religious Affiliation: ______

Previous Address: ______ Church/Temple: ______

______ Own or Rent: ______

Are you a US citizen? ❑ *Yes* ❑ *No* Date of Citizenship: ______ Birth Place: ______

Military Service: ❑ *Yes* ❑ *No* Branch of Service: ______ Dates: ______

Did your spouse ever serve in the US Military? ❑ *Yes* ❑ *No* Branch of Service: ______

HEALTH INSURANCE INFORMATION

(Please enclose copies of both sides of all health insurance cards.)

Social Security Number: ______ Primary Insurance: ______

Medicare Number: ______ Medicaid Number: ______

Part A: ❑ *Yes* ❑ *No* Part B: ❑ *Yes* ❑ *No*

Part D *(Prescription Drug Plan)*: ❑ *Yes* ❑ *No* Name: ______

Supplemental Insurance: ❑ *Yes* ❑ *No* Plan Name/Number: ______

Medicare Advantage Plan: ❑ *Yes* ❑ *No* Plan Name/Number: ______

LONG TERM CARE INSURANCE

(Policies that were pre-certified under the Connecticut Partnership for Long Term Care will receive a 5% discount off the private pay rate.)

Name: ______ Policy Number: ______

Phone Number: ______ Copy of the policy provided: ❑ *Yes* ❑ *No*

FAMILY CONTACTS

(Please list in order that they should be contacted on your behalf.)

1. ______
Name *Relationship* *Phone Number*
______
Address *Email Address*

2. ______
Name *Relationship* *Phone Number*
______
Address *Email Address*

3. ______
Name *Relationship* *Phone Number*
______
Address *Email Address*

Resident's Name ______________________ Date ____/____/20____

FORMER OCCUPATION / INTERESTS

Former Occupations: ______________________

____

Company: ______________________ Retirement Date: ______________________

Education: ______________________

Special Interests/Hobbies: ______________________

Clubs or Organizations Belonged to: ______________________

Previous Volunteer Experience: ______________________

PRIMARY CARE PHYSICIAN / SPECIALISTS

Primary Care Physician: ______________________

Address: ______________________ Phone: ______________________

Specialist(s): ______________________

Address: ______________________ Phone: ______________________

Specialist(s): ______________________

Address: ______________________ Phone: ______________________

RECENT HOSPITALIZATIONS

1. ______________________
Hospital Name *Date*
____
Reason

2. ______________________
Hospital Name *Date*
____
Reason

RECENT SKILLED NURSING FACILITY STAYS

1. ______________________
Hospital Name *Date*
____
Reason

2. ______________________
Hospital Name *Date*
____
Reason

MENTAL HEALTH HISTORY

____

____

____

____

Resident's Name ___________________ Date ___/___/20___

FINANCES

Who handles your finances currently? ______________________ (Name) ______________________ (Relationship)

Upon admission to Elim Park, who will manage your finances? ______________________ (Name) ______________________ (Relationship)

______________________ (Address) ______________________ (Phone Number)

If you plan to handle your own finances, please describe the arrangements you have made in the event that you should become unable to do so: ______________________

____

____

MONTHLY INCOME

(Include spouse's income.)

Social Security Amount	$	Veteran's Income	$
Supplemental Security Income	$	Teacher's Income	$
Retirement Income	$	Occupation	
Pension Income	$	Pension Name	
Pension Income	$	Pension Name	
Annuity Income	$	Annuity Income	
Other Income	$	Source	

Please include proof of all income (gross amount).

ASSETS

(Include spouse's assets.)

INSTITUTE/BANK NAME	ACCOUNT TYPE	ACCOUNT NO.	NAMES ON ACCOUNT	ACCOUNT BALANCE
				$
				$
				$
				$
				$

Please include current bank statements for each account.

Are there any liens or encumbrances on your assets, including mortgages or other debts? If so, please describe:

____

____

Do you or your spouse receive income from, or have an interest in a trust? Does your legal representative (or other person completing the application on your behalf) receive income from, or have interest in a trust? If yes, please provide a copy of the trust instrument and the name, address, and telephone number of the Trustee. ❑ *Yes* ❑ *No*

Resident's Name ______________________ Date ___/___/20___

FUNERAL ARRANGEMENTS

(Please provide information regarding your funeral arrangements/wishes.)

Funeral Home: ______________________ Contact: ______________________

Address: ______________________ Phone Number: ______________________

Cemetery Plot Location: ______________________ Stone in Place? ☐ *Yes* ☐ *No*

Irrevocable Prepaid? ☐ *Yes* ☐ *No* Amount: ______________ Date Arranged: ______________

REAL ESTATE

(Owned within the last 60 months / 5 years.)

Address: ______________________ Est. Value: ______________________

Jointly Owned: ☐ *Yes* ☐ *No* With Whom? ______________________

Life use of any property? ☐ *Yes* ☐ *No* If yes, property address: ______________________

OTHER ASSETS

(Attach additional sheets if required, along with proof of assets/value.)

Stocks: ______________________ Value: ______________________

Bonds: ______________________ Value: ______________________

Investments: ______________________ Value: ______________________

Life Insurance: ______________ Cash Value: ______________ Face Value: ______________

Have any of your assets been sold, transferred or gifted in the last 5 years/60 months? ☐ *Yes* ☐ No

If so, please describe: ______________________

	Yes	No	Whom	Contact Information
Living Will	☐	☐		
Health Care Rep.	☐	☐		
POA for Finances	☐	☐		
Conservator	☐	☐		
Power of Attorney	☐	☐		

By signing this form, I certify that all of the information and documentation provided is true, complete and accurate. I agree to notify Elim Park as soon as possible of any change to the information provided or upon learning that any information/documentation is inaccurate, incomplete or false. I understand that Elim Park is considering me for admission to its facility and may admit me in reliance on information provided and related representations.

______________________ ______________________

Signature of Applicant ***Date***