Hamden Rehabilitation
AND HEALTH CARE CENTER

Dear Applicant,

Thank you for your interest in Hamden Rehabilitation and Health Care Center.

We realize that the process of transferring a loved one to a care center can be daunting, regardless of whether the need is for short-term recovery or extended care. Our team of healthcare professionals is here to provide the support you need to make this experience a positive one.

Our skilled nursing facility takes immense pride in delivering the highest quality short-term stay recovery programs, extended care as well as memory care. Physical, Occupational and Speech therapy services can be provided on both an inpatient and outpatient basis.

As promised, enclosed you will find the application for admissions. This application must be completed to be considered for admission and placement on our waiting list.

We would enjoy showing you our beautifully appointed facility. Please call our Admission Office at (203) 281-7555 to schedule your personal tour.

Sincerely,

Leanne Coppola, BSW

Director of Admissions

1270 Sherman Lane, Hamden, Connecticut 06514 ***Phone:*** *(203) 281-7555* *Fax: (203) 281-3827*
www.hamdenhealthcare.com

Hamden Rehabilitation and Health Care Center

APPLICATION FOR ADMISSION

Date of Application_____

Referral/Source of Information_____ Telephone#_____

I. GENERAL INFORMATION

Resident's Name_____

Home/Previous Address_____ Home Phone#_____

Present Location_____
If a medical facility, date of admission_____

Date of Birth_____ Birth Place_____ Veteran or Spouse of Veteran_____

Marital Status_____ If widowed, how long?_____

A. REASON PLACEMENT IS REQUESTED

_____

_____

Anticipated Length of Stay_____

Have you or the physician discussed the possibility of placement with this person?_____

Family's Attitude Toward Placement_____

Resident's Attitude Toward Placement_____

Previous Experience in Group Living_____

Is a home care agency or other community services involved with this person? Yes_____No____
If yes, which agency(s)?_____

B. AFTER CARE PLANS

Will prior living accommodations be available after placement?_____

_____

II. SOCIAL INFORMATION

Birthdate_____ Birthplace_____ Primary Language_____

Marital Status_____ If widowed, how long?_____ No. of Children_____

Education_____ Religion_____Parish_____

Former Occupation_____

Special Interests/Skills and are these skills preserved?_____

_____

Membership in Community/Civic Organizations_____

Food Preferences_____

Does individual like to have a drink?_____Type_____When?_____
Smokes? Yes_____No____

Describe current living arrangements. Individual living alone, with family or friend?

_____

Present Interests/Strengths (include a description of daily pattern)

_____

_____

Next of Kin (Please include both home and business telephone numbers)

Name	Relationship	Address	Phone

III. FINAL ARRANGEMENTS (THIS SECTION MUST BE AVAILABLE UPON ADMISSION)

Funeral Home Director:_____

Name Address Phone

Prepaid Burial Account? Yes_____No_____

Special instructions (i.e. cremation, organ donations, special services or funeral home contracts) Please include telephone numbers and copies of contracts if possible.

_____

_____

_____

_____

_____

IV. MEDICAL INFORMATION

(THIS FORM MUST BE COMPLETED BY CURRENT PHYSICIAN)

Information from:_____ Resident's Name:_____

Facility:_____ D.O.B.:_____

Date & Time:_____ To Be Admitted:_____

Current Medical and Health Status:

Primary Secondary Diagnosis (If CVA/MI-specify date):

_____

_____

Medications Route Dose Frequency Medications Route Dose Frequency

_____

_____

_____

_____

_____

Treatments:

_____

Allergies or Sensitivities:

_____

Skin Conditions/Rashes:

_____

Type of Diet:_____ Height:_____ Weight:_____

Functional Assessment Codes:

I=Independent A=Assist S=Supervise U=Unable

1. Mobility:

   Walks ( ) Type of Aid:_____ # of Staff to Assist:_____

   Wheelchair ( ) Transfers ( ) Pivots ( ) # of Staff to Assist:_____

2. Prior Hospitalization(causes)_____

   _____

   _____

   _____

3. Personal Care: (check appropriate block)

Dress ( ) Bathing ( ) Toileting ( ) Feeds Self ( ) Assist ( ) Needs to be Fed ( )

Continent: Bowel Y_____N_____ Bladder Y_____N_____Incontinent at Times Y_____N_____

Foley Y_____N_____ Colostomy Y_____ N_____

Hard of Hearing Y_____N_____ Hearing Aids Y_____N_____

Sight Impaired Y_____N_____ Glasses Y_____N_____

4. Mental Status: (Code: A=Always S=Sometimes N=Never)

Alert ( ) Confused ( ) Forgetful ( ) Oriented ( ) Restless ( )

Depressed ( ) Vague ( ) Non-Responsive ( )

5. Behavior Patterns

Wanders Yes ( ) No ( ) Combative Yes ( ) No ( )

Paces Yes ( ) No ( ) Resistive to Care Yes ( ) No ( )

6. Equipment: (check applicable)

Egg Crate Mattress ( ) Air Mattress ( ) Head Board ( ) Cradle ( )

Water ( ) Mattress ( ) Trapeze ( ) Feeding Pump ( ) Oxygen ( )

Other ( ) Specify:_____

7. Therapies:

Physical Therapy Y_____N_____ Number of Days/week_____

Occupational Therapy Y_____N_____ Number of Days/week_____

Speech Therapy Y_____N_____ Number of Days/week_____

Previous Medical History:

1. Surgeries (include dates) :_____

_____

2. Prior Hospitalizations

(causes):_____

_____

_____

3. Institutionalizations Y_____N_____ Adult Day Care: Y_____N_____

History of Psychiatric Illness: Y_____N_____

Substance Abuse or Alcoholism: Y_____N_____

If "yes" to any box in #3 please describe:_____

_____

4. If there is any other pertinent information you think we should know, do so in the space provided:

_____

_____

_____

Present Physician:_____ Dentist:_____

Will physician follow? Y_____N_____ If "NO" would you like a member of our medical staff?

Y_____N_____

Name:_____

Signature of Physician Completing Medical and Health Status Form:

_____ _____

Physician's Signature Date

_____

Street Address

_____ (_____)_____

City State Zip Code Area Code --Telephone #

Level of care recommended by physician: SNF:_____

Short Term Rehabilitation: Y_____N_____

APPLICANT'S FINANCIAL STATEMENT

Please note that the facility is relying upon the truth and accuracy of the following disclosures in assessing eligibility for admission and/or continuing residence.

Income:

Applicant's Income (from all sources)

Source: _____ Amount: _____ Frequency:_____
Source: _____ Amount: _____ Frequency:_____
Source: _____ Amount: _____ Frequency:_____
Source: _____ Amount: _____ Frequency:_____

Spouse's Income (from any source)

Source: _____ Amount: _____ Frequency:_____
Source: _____ Amount: _____ Frequency:_____
Source: _____ Amount: _____ Frequency:_____
Source: _____ Amount: _____ Frequency:_____

Assets

1. *Real Estate*:

Primary Address: _____ Value: _____ Equity:_____

Ownership: Sole Joint Marital Spousal Residence: Yes No

Additional Real Estate (list by address):

_____
_____
_____
_____

2. *Stocks, Bond, Money Market Accounts, CDs, etc. (list all by type, account no. and value)*:

_____ Value: _____
_____ Value: _____
_____ Value: _____
_____ Value: _____
_____ Value: _____
_____ Value: _____

3. *Bank Accounts (list all by type, account no. and balance)*:

Type: _____ Account No._____ Balance: _____
Type: _____ Account No._____ Balance: _____
Type: _____ Account No._____ Balance: _____

4. *Life Insurance Policies*:

Company: _____ Policy No.: _____ Cash Value: _____
Company: _____ Policy No.: _____ Cash Value: _____
Company: _____ Policy No.: _____ Cash Value: _____

5. *Annuities (list by company and account no.)*:

_____
_____
_____

6. *Trusts (list all for which the resident is the settlor or beneficiary and provide copy)*:

_____
_____

Asset Transfers and Gifts:

List all asset transfers and gifts within the past 60 months that exceed $1,000. This includes any asset: cash, property, securities, etc. and includes transfers to any trust)

_____
_____
_____
_____
_____

Certification

If signed by 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 for less than fair market value in excess of $1,000 and any trusts created or transfers of assets to any trust that I or my spouse have made.

_____
Applicant

If signed by Responsible Party:

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 and any trusts created or transfers of assets to any trust that the applicant or his or her spouse has made.

_____
Responsible Party/Legal Representative

_____
Print

_____
Date

V. REFERRAL

FROM WHAT SOURCE(S) DID YOU AND/OR THE PROSPECTIVE RESIDENT HEAR ABOUT OUR FACILITY?

_____HOSPITAL (please name)_____

_____PHYSICIAN_____

_____STAFF FROM_____

_____PATIENT FROM_____

_____PERSONAL EXPERIENCE WITH_____

_____LAWYER_____

_____TRUST OFFICER_____

_____HOME HEALTH AGENCY_____

_____SENIOR CITIZEN ORGANIZATION_____

_____NEWSPAPER STORY [ ] OR NEWSPAPER AD [ ]

WHICH NEWSPAPER?_____

_____RADIO_____

_____LETTER FROM_____

_____SEMINAR SPONSORED BY_____

_____OPEN HOUSE_____

_____OTHER (please specify)_____

Of all the sources you checked, which were the most influential?

_____

_____

Comments:_____

_____

_____

YOU HAVE CONTACTED THIS NURSING HOME AND INDICATED A DESIRE TO BE ADMITTED AS A PATIENT TO THE FACILITY. BECAUSE OF THIS, YOU HAVE BEEN ISSUED A RECEIPT INDICATING THE DATE AND TIME OF YOUR INITIAL REQUEST. IN ADDTION, YOU NAME HAS BEEN PLACED ON OUR DATED LIST OF APPLICATIONS OR INQUIRY LIST.

AS SOON AS YOU SUBSTANTIALLY COMPLETE AND RETURN THE ENCLOSED APPLICATION TO THIS FACILITY; YOUR NAME WILL BE PLACED ON OUR WAITING LIST FOR ADMISSION.

NON-DISCRIMINATION NOTICE TO APPLICANTS FOR ADMISSION.

THIS FACILITY IS PROHIBITED BY PUBLIC ACT NO. 80-364. EFFECTIVE OCTOBER 1, 1980 FROM DISCRIMINATING AGAINST INDIGENT APPLICANTS FOR ADMISSION ON THE BASIS OF SOURCE OF PAYMENT. INDIGENT APPLICANTS WHO BELIEVE THEY HAVE BEEN DISCRIMINATED AGAINST ON THE BASIS OF PAYMENT SOURCE MAY MAKE A COMPLAINT TO THE REGIONAL OMBUDSMAN WHO WILL CONDUCT AN INVESTIGATION ON THE COMPLAINT AND REPORT HIS/HER FINDINGS TO THE DEPARTMENT OF INCOME MAINTENANCE.

REGIONAL OMBUDSMAN.....BRENDA FOREMAN
TELPHONE NUMBER.....1-866-388-1888
ADDRESS.....401 WEST THAMES STREET
NORWICH, CONNNECTICUT 06360