Sheltering Arms
165 McKinley Avenue
Norwich, CT 06360
860-887-5005
860-892-2340 fax

APPLICATION FOR ADMISSION

Date Received: _____

1. *PERSONAL INFORMATION*

Name: _____ Maiden Name: _____ Likes to be Called: _____

Phone: _____ Address: _____ City: _____

State: _____ Zip: _____ Place of Birth: _____ Date of Birth: _____ Age: ____

Marital Status: _____ Name of Contact: _____

Contact Phone: _____ Email: _____

2. *GENERAL INFORMATION*

Primary Language Spoken: _____ Other Languages: _____

Religion: _____ Highest Level of Education Completed: _____

Applicant's former occupation: _____Year of Retirement: _____

Veteran/Spouse of a Veteran: _____ Veteran's Dates of Service: _____

Primary Care Physician: _____ Phone: _____

With whom is the applicant living now? _____

Applicant is presently at: Home _____ Hospital _____ Nursing Facility _____ other _____

Name of any prior Nursing Facility(s): _____ Date(s): _____

Hobbies, Interests, Special Talents: _____

3. *EMERGENCY CONTACTS*

NAME	RELATIONSHIP POA Yes [ ] No [ ]	CONSERVATOR Yes [ ] No [ ] PERSON Yes [ ] No [ ] FINANCE Yes [ ] No [ ]
ADDRESS	TOWN	ZIP
EMAIL ADDRESS	HOME TELEPHONE WORK TELEPHONE	CELL PHONE

NAME	RELATIONSHIP POA Yes [ ] No [ ]	CONSERVATOR Yes [ ] No [ ] PERSON Yes [ ] No [ ] FINANCE Yes [ ] No [ ]
ADDRESS	TOWN	ZIP
EMAIL ADDRESS	HOME TELEPHONE WORK TELEPHONE	CELL PHONE

4. ***HEALTH INFORMATION***

Please list/describe current medical condition: _____

_____

_____Allergies:_____

Current Medications: _____

_____

Has the applicant ever received psychiatric treatment (yes/no)? _____ Please Explain: _____

_____

_____

Any Criminal History? _____ Smoking (Tobacco) History: _____ Current (yes/no) ___

Does Applicant Require any assistance with any of the following:

Bathing ____ Dressing ____ Medication Administration ____ Personal Hygiene _____

Are there any problems with Incontinence? Bladder _____ Bowel _____

Does applicant wear pads or undergarments for incontinence? Never _____ Sometimes _____ Always _____

Does the applicant require any special equipment? (walker, oxygen, nebulizer) _____

5. ***FINANCIAL INFORMATION -*** **This information will be kept Confidential**

Social Security Number _____ - ____ - _____ Medicare Number: _____ Part A: _____ Part B: _____

Medicaid Number: _____ Medicaid Application Pending (yes/no): _____

Medicare Part D or Pharmacy Drug Plan: _____

Insurance Company: _____ Policy Number: _____

Long-term Care Insure Policy (yes/no): _____ If yes, Insurance Company: _____

Policy Number: _____ Is applicant on CT Homecare Program for Elders (yes/no):_____

If yes, Case Manager: _____ If no, is application pending? _____

Applicant's Monthly Income:

Social Security: $_____ Pension/Retirement: $_____Which Company: _____

VA Benefit: $_____ Annuities: $_____ Mutual Funds: $_____

Railroad/Teachers Retirement: $_____ Miscellaneous: $ _____

Total Monthly Income: $_____

Applicant's Bank Accounts

Bank	**Acct #**	**Type**	**Name (s) on Account**	**Balance**

Does the applicant own any stocks (yes/no)? _____

Company Name: _____ Value: _____

_____ Value: _____

Real Estate/Property

Does the applicant own any real estate (yes/no)? _____

Please describe, including location and value: _____

_____

Has the applicant sold or given away any real estate in the past 2 years (yes/no)? _____

Please explain: _____

Is the applicant's spouse living in the house now (yes/no)? _____

Does the applicant own an automobile (yes/no)? _____

Have you made prepaid funeral arrangements (yes/no)? _____

Name of Funeral Home: _____

Life Insurance Company	**Policy #**	**Type of Policy**	**Face Value**

Trust

Does the applicant receive income from of have any interest in any trust (yes/no)? _____

Please Describe: _____

Name of Trust Officer: _____

Address: _____

Phone: _____ Do you anticipate applying for Medicaid (yes/no)? _____

If yes, when do you anticipate you will apply? _____

Gifts, Transfers of Cash, or Transfers to an Irrevocable Trust with last 24 months (yes/no): _____

Type of Transfer	Value	To Whom	Address	Relationship	Date of Transfer

Do you have an attorney (yes/no)? _____ Name: _____

Address: _____

Phone: _____

6. ***APPLICATION CONTACT INFROMATION***

Person responsible for payment of account:

Name: _____ Relationship: _____ Home Phone: _____

Work Phone: _____ Address: _____ State: ____ Zip: _____

Person to receive inquiries about waiting list:

Name: _____ Phone: _____

Address: _____ Town: _____ State: ____ Zip: _____

Please Provide the Following Information with this Application

- Photocopy of Medicare/ Medicaid card
- Photocopy of Insurance card(s)
- Photocopy of Living Will, if applicable
- Photocopy of POA or Conservator Appointment, if applicable
- Driver's License/Photo ID

The information presented in this financial disclosure is correct to the best of my knowledge. My signature indicated that I understand that UCFS is relying on the information and representation I have provided and will be used in deciding whether to admit the UCFS applicant. This information may be used in applications to apply for funding.

Signed: _____ Date: _____

Print Name: _____ Date: _____

Relationship to Applicant: _____ Date: _____