UCFS Eldercare

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: _____ Marital Status: _____ Gender: _____

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

Name of Primary 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: _____

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): _____

Do you have a Case Manager? Yes [ ] No [ ] If *yes*, will these services continue if you move here? Yes [ ] No [ ]

If *no*, who will provide your support services and/or transportation to medical appointments?

_____

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*

Primary Care Physician: _____Address:_____ Phone: _____

Please list/describe current medical conditions: _____

_____

_____Allergies:_____

Current Medications: _____

_____

_____

Other Physicians Providing Care: (*Dentist, Ophthalmologist, specialists, etc***):**

Type of Physician:_____ Name:_____ Phone:_____

Type of Physician:_____ Name:_____ Phone:_____

Type of Physician:_____ Name:_____ Phone:_____

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Does Applicant Require any assistance with any of the following:

Bathing [ ] Dressing [ ] Medication Administration [ ] Personal Hygiene [ ]

Other [ ] explain_____

Are there any problems with Incontinence? Bladder Yes [ ] No [ ] Bowel Yes [ ] No [ ]

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

Vision: Good [ ] Fair [ ] Poor [ ] Glasses [ ] **Hearing**: Good [ ] Fair [ ] Poor [ ] Aides [ ]

Walking: Independent/with ease [ ] Cane [ ] Walker [ ] Wheelchair [ ] Scooter [ ]

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

Dietary Requirements: _____

Food dislikes/allergies/sensitivities:_____

Favorite foods:_____

Does the applicant prefer: Being Alone [ ] Being with a Group [ ] Quiet Lifestyle [ ] Active Lifestyle [ ]

Has the applicant ever received psychiatric treatment Yes [ ] No [ ] Please Explain: _____

_____

_____

Does the applicant have any emotional/behavioral concerns (depression, anger, mood changes) Yes [ ] No [ ]

If *yes*, explain _____

Any Criminal History? _____ Smoking (Tobacco) History: _____ Current Yes [ ] No [ ]

Alcohol History: Current Yes [ ] No [ ] If *yes*, explain _____

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 Supplement Number: _____ Medicare Part D or Pharmacy Drug Plan: Yes [ ] No [ ]

Insurance Company: _____ Policy Number: _____

Long-term Care Insurance 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: ***Please list all income*** *including but not limited to Social Security, Supplemental Security Income, Pensions, VA Benefits, Workman's Compensation, Annuities, Rental Income, Alimony, etc.*

Social Security: $_____ Are Medicare D premiums being deducted from these fund? Yes [ ] No [ ]

If yes, how much is being deducted? $_____ Pension/Retirement: $_____ Company: _____

VA Benefits: $_____ Annuities: $_____ Mutual Funds: $_____

Railroad/Teachers Retirement: $_____ Miscellaneous/Alimony: $ _____

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: _____

Has the applicant ever been evicted from a previous residence Yes [ ] No [ ]

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 [ ] Amount of Arrangements: $_____

Name of Funeral Home: _____

Do you have any Life Insurance Policy Yes [ ] No [ ]

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

Trust

Does the applicant receive income from or 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 INFORMATION***

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

I certify that the applicant's disclosed financial records are a true and complete statement of the applicant's current income and assets. Furthermore, I understand that if the applicant receives Medicaid assistance, any income from pension, social security or alimony, will be forwarded as applied income to Sheltering Arms at the beginning of each month.

My signature certifies that I understand that UCFS is relying on the information and representation that 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: _____