Application for Admission

Manchester
REHABILITATION AND HEALTHCARE CENTER

385 West Center Street
Manchester, CT 06040-4797
Phone: 860.646.0129
Voice Mail: 860.647.7828
Fax: 860.645.0841
manchesterrhc.com

Applicant's Full Name

You have contacted this nursing home and indicated a desire to be admitted as a patient to this facility. Because of this, you have already been issued a receipt indicating the date and time of your initial request and your name has been placed on our dated list of applications or inquiry list.

Please find enclosed this facility's written application form. As soon as you substantially complete and return the form to the facility, your name will be placed on our waiting list for admission to the facility.

Your name will only be placed on our waiting list after you substantially complete and return this written application form to us.

Vernon
REHABILITATION AND HEALTHCARE CENTER

180 Regan Road
Vernon, CT 06066-2824
Phone: 860.871.0385
Ext. 4312 or 4357
Fax: 860.870.2591
vernonrhc.com

How did you hear about us?

☐ From a friend or family member
☐ Website
☐ From a blog
☐ Facebook
☐ Internet search
☐ From my doctor or hospital
☐ Radio advertisement
☐ Newspaper advertisement
☐ From an event I attended
☐ Other (please specify): _____

APPLICATION FOR ADMISSION

Manchester ____ Vernon ____

For Facility Use Only
Type of Admission: Long-term ____ Hospice ____ Respite ____ Alzheimer's ____
Subacute: Short Term Rehab ____ IV Therapy ____ Cardiac ____ Respiratory ____

I. PERSONAL INFORMATION

NAME			MAIDEN NAME		TELEPHONE
ADDRESS/STREET			CITY	STATE	ZIP
PLACE OF BIRTH	DATE OF BIRTH	AGE	MARITAL STATUS	SEX	FUNERAL HOME

II. GENERAL INFORMATION

Religious Affiliation: ___________________________ Name of Church ____________________________

Pastor's Name: __________________________________ Telephone: _______________________________

Applicant's former occupation: ______________________ Name of last employer: ___________________

Date of Retirement _____________ With whom is the applicant living now? ______________________

Veteran / Spouse Veteran: _____ Dates of Service: ____________ Educational Background: ___________

Name of Personal Physician: _________________________________ Telephone: _____________________

Medicare Part D Pharmacy Drug Plan: ______________________________

Applicant is presently at: Home ____ Hospital ____ Nursing Facility ____ Other _____________________

Name of any prior Nursing Facility(s): _______________________________ Date(s): ________________

III. EMERGENCY CONTACTS

NAME		RELATIONSHIP	POA YES [ ] NO [ ]	CONSERVATOR YES [ ] NO [ ]
ADDRESS		TOWN		ZIP
HOME TELEPHONE	WORK TELEPHONE		CELL PHONE	

NAME		RELATIONSHIP	POA YES [ ] NO [ ]	CONSERVATOR YES [ ] NO [ ]
ADDRESS		TOWN		ZIP
HOME TELEPHONE	WORK TELEPHONE		CELL PHONE	

NAME		RELATIONSHIP	POA YES [ ] NO [ ]	CONSERVATOR YES [ ] NO [ ]
ADDRESS		TOWN		ZIP
HOME TELEPHONE	WORK TELEPHONE		CELL PHONE	

IV. BILLING INFORMATION

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

Medicaid Number: _____ Medicaid Application Pending: Yes _____ No _____

Insurance Company: _____ Policy Number: _____

Long-term Care Insurance Policy: Yes _____ No _____ CT Partnership Policy? Yes _____ No _____

Name of Agent / Insurance Company: _____

Policy Number: _____ Telephone: _____

Do you receive Medicare from a Disability? Yes _____ No _____

Have you received Physical Therapy, Occupational Therapy or Speech Therapy Services covered by Medicare Part B in the past year? Yes _____ No _____ If so, which facility: _____

Applicant's Total Assets	**Applicant's Total Income**
Certificates of Deposit……. $ _____	**Social Security……. $ _____**
Mutual Funds……. _____	**Pension……..…. _____**
Securities…… _____	**Annuities……..…..... _____**
Cash (Include all Checking	**Interest……..….... _____**
& Savings Account)…….. _____	**Dividends…….…..... _____**
Value of House, if owned by applicant _____	
Applicant's equity (ownership) in house $_____	**Miscellaneous……..... _____**
Does spouse reside in house? Yes ____ No ____	
Other Real Estate…….. _____	**Total…….……. $ _____**
Miscellaneous…… _____	
Total Assets…….. $ _____	**Life Insurance Policy(s)**
Less Total Liabilities……. _____	**Total Cash Surrender Value $ _____**
Net Total Assets…… _____	**Total Value of Trust Funds $ _____**

Do you anticipate applying for Medicaid? Yes_____ No _____

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

Gifts, Transfers of Assets, and Transfers to an Irrevocable Trust within last 60 months:

Type of Transfer	Value	To Whom	Address	Relationship	Date of Transfer

Person responsible for payment of account: **Name: _____**

Relationship: _____ Telephone: Home _____ Work _____

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

Person to receive inquiries about waiting list placement: **Name: _____**

Address: _____ Town: _____State: _____ Zip: _____

✓ **THE FOLLOWING ITEMS ARE REQUIRED TO PROCESS THE APPLICATION:**

☐ **Photocopy of Medicare card**

☐ **Photocopy of Insurance card(s)**

☐ **Photocopy of Living Will, if applicable**

☐ **Photocopy of Attorney Agreement, if applicable**

☐ **Photocopy of Conservator Appointment, if applicable**

I hereby certify that this is a true and complete statement of my current income and assets and any gifts, transfer of assets, and/or transfers of assets to an irrevocable trust within the last sixty (60) months prior to the date of this application. If necessary, I authorize the above stated nursing facility to contact my bank references or to request a credit report and that, if such report is requested, I will be notified and given an opportunity to examine the results.

All persons, in dealing or making any agreement with the management of Manchester Manor Health Care Center or Vernon Manor Health Care Center thereby agree to look solely to the Facility itself, and not the management as individuals, for the enforcement of any rights, claims, demands or obligations accruing to such persons; and it is expressly acknowledged that none of the management individuals assume any personal liability for such rights, demands, or obligations.

Signed: _____ Date: _____

Applicant or Responsible Party

For Facility Use Only

Person Contacted	Date	Comment

Rev. 4/15/13

Please fill out this form and email it ahardy@vernonrhc.com