APPLICATION FOR ADMISSION

You have contacted this nursing home and indicated a desire to be admitted as a resident to this facility.

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.

856 Maple Street • Rocky Hill, CT 06067 • Phone: (860) 563-2861 • Fax (860) 257-9128

PERSONAL INFORMATION

Applicant's Name ____

Home/Previous Address ____

Present Location/Address ____

If a medical facility, date of admission ____

Date of Birth ______________ Age ________ Birthplace ________________ Religion ________________

Marital Status ______________ Previous Occupation ________________ Education ________________

Hobbies/Interests (Past & Present) Veteran (spouse of) Yes_______ No_______

____ Veteran Service # ______________

____ Branch of Service ______________

Primary Contact Person ________________________________ Relationship ________________

Address ____

Telephone: Days ________________________ Evenings ________________________

POA __________ Conservator: Person ______________ Estate ______________ (Please include documentation)

Other Involved Parties

Name ____ Relationship ________________

Address ____

Telephone: Days ________________________ Evenings ________________________

Name ____ Relationship ________________

Address ____

Telephone: Days ________________________ Evenings ________________________

MEDICAL INFORMATION

Name/address of current physician ____

____ Phone # ________________

Names/addresses of all previous physicians and hospitalizations (and dates hospitalized)

____

____

____

Is applicant receiving community services? If so, please list agencies & contact person.

____

____

Reason placement is needed ____

Attitude towards placement: Applicant ________________________ Family ________________

Anticipated length of stay ____

Diagnosis ____

Medications ____

What assistance does applicant require with personal care (i.e. dressing, eating, walking, etc.)?

____

____

Please list mental limitations or behavioral difficulties and successful management techniques.

____

____

FINANCIAL INFORMATION

Social Security #_______________________________ Medicare #______________________________ Part A _________

Part B ___________

Medicaid (State Assistance) #____

Does applicant have an application pending for State Medical Assistance (Title 19)? ____________________________

If yes, date application submitted _______________ District Office________________ Caseworker _______________

Other Medical/Hospital Insurance:

Name of Company	Subscriber/Group #	Type of Insurance
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

Life Insurance. (List only policies having a cash surrender value and give approximate cash surrender value): __________

____

Has applicant established an irrevocable burial account? ____

If so, name of funeral home and amount ____

INCOME

Social Security	$ __________________________/Mo.		
Pensions	$ __________________________/Mo.	Source	____________________________________
VA Benefits	$ __________________________/Mo.		
Annunities	$ __________________________/Mo.	Source	____________________________________
Interest	$ __________________________/Mo.	Source	____________________________________
Dividends	$ __________________________/Mo.	Source	____________________________________
Other	$ __________________________/Mo.	Source	____________________________________

Do you receive income from or have any interest in any trust? ____

If yes, please describe and provide a copy of the trust instrument.

____

____

ASSETS (If any asset is jointly held, please give name of joint owner).

Real Estate

Does applicant own any real estate? Yes _________________________ No _________________

Description of Property	Approximate Value	Name(s) on Deed
______________________________	______________________________	______________________________
______________________________	______________________________	______________________________

Are there any liens or mortgages against the property? Yes _________________ No_________________

If yes, in the amount of $ ____________________________________ payable to __________________________________

Was this real estate your home prior to entering the nursing home? Yes _________________ No_________________

Is your spouse now living in the home? Yes _________________ No_________________

Do you have a "life use" of any real estate (any ownership interest, in full or in part, for your lifetime, or the right to occupy property for your lifetime)? Yes _________________ No_________________

If yes, please describe ____

____

____

Cash Assets

Please list all assets including but not limited to: Savings Accounts, Checking Accounts, Stocks, Bonds, C.D.'s

Name of Institution	Account #	Present Balance

Transfer of Assets

Within sixty (60) months prior to the date of this application, have you given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind (cash, securities, real estate, etc.) for less than fair market value? If so, please describe fully all such gifts or transfers in excess of $1000, including the asset transferred, names, addresses and relationship to you of the person to whom the gift or transfer was made, and the value of the gift or transfer.

Gifts or transfers within 60 months: Yes __________________ No__________________

Please describe ____

____

____

____

Within sixty (60) months prior to the date of this application, have you created any trusts or placed funds or any other assets in a trust that already existed?

Yes _______________ No________________ If yes, please describe and provide a copy of the trust instrument.

____

____

I hereby certify 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 they have made within the sixty (60) months prior to the date of this application.

____
(Applicant)

____
(Responsible Party)

____
(Date)

(PLEASE RETURN WITH APPLICATION)

Maple View Health & Rehabilitation Center has a provider agreement with the State of Connecticut to provide services to Medicaid recipients pursuant to Title XIX of the Social Security Act, and to provide services to Medicare recipients pursuant to Title XVIII of the Social Security Act.

State and federal law and regulations impose the following limitations on the advance payment and deposit requirements of nursing homes:

- No nursing home may request an advance payment or deposit from a Medicare beneficiary for any services or supplies covered by Medicare as a condition of admission.
- A nursing home may request an advance payment or deposit of up to one thousand five hundred dollars ($1,500.00) from an applicant who has applied for Medicaid, provided such payment or deposit is held in an account for the applicant's benefit and returned to the applicant when he is determined eligible for Medicaid.
- No nursing home may request an advance payment or deposit from a Medicaid recipient as a condition of admission.
- Upon admission, **Maple View Health & Rehabilitation Center** requires self-pay residents or their responsible party, to pay the facility an advanced room and board payment equal to thirty (30) days at the current self pay per diem rate.

Public Act 91-8 (9/4/91) provides that nursing facilities with a census of 30% or less of private pay residents shall not be required to admit an indigent person on a waiting list during the subsequent six (6) months, provided that no bed be held open for more than (30) thirty days.

In compliance with State and Federal laws, **Maple View Health & Rehabilitation Center** admits and treats all residents equally, regardless of race, color, sex, national origin, or source of payment.

Continued on page 2

(PLEASE RETURN WITH APPLICATION)

I acknowledge that I have received a copy of this statement. The facility has explained the information in the statement to me, and I am signing this statement to show that I understand it.

_______________________________ _______________________________

Name of Resident **Signature of Resident**

-OR-

_______________________________ _______________________________

Name of Representative **Signature of Representative Party***

____

Date

*If a representative party is signing this form on behalf of the resident, indicate below his or her relationship to the resident.

____

THIS NOTICE MUST BE SIGNED AND RETURNED TO US BEFORE WE CAN ADMIT ANY RESIDENT.