

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





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



Application for Admission

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.

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 Manor Vernon Manor					
Type of Admission: Long-term Subacutes	n Hospice Resp : Short Term Rehab			Respirato	ory
I. PERSONAL INFORMATIO	N				
NAME		MAIDE	N NAME	Т	ELEPHONE
ADDRESS/STREET		CITY	S	TATE Z	IP
PLACE OF BIRTH	DATE OF BIRTH	AGE MARIT	AL STATUS SH	EX F	UNERAL HOME
II. GENERAL INFORMATION	Ī		1	,	
Religious Affiliation:	Nam	e of Church			
Pastor's Name:	T	elephone:			
Applicant's former occupation: _					
Date of Retirement					
Veteran / Spouse Veteran:	Dates of Service:	Educationa	al Background:		
Name of Personal Physician:		Telepho	one:		
Medicare Part D Pharmacy Drug	Plan:				
Applicant is presently at: Home _			ther		
Name of any prior Nursing Facili		·	Date(s):		
NAME	,	RELATIONSHIP	POA	I	CONSERVATOR
				NO[]	YES[] NO[]
ADDRESS		TOWN			ZIP
HOME TELEPHONE	WORK TELEPHONE		CELL PHONE		
NAME	I	RELATIONSHIP	POA		CONSERVATOR
			YES[]	NO[]	YES[] NO[]
ADDRESS		TOWN			ZIP
HOME TELEPHONE	WORK TELEPHONE		CELL PHONE		
NAME	1	RELATIONSHIP	POA		CONSERVATOR
4 PPPPEGG		move	YES[]	NO[]	YES[] NO[]
ADDRESS		TOWN			ZIP
HOME TELEPHONE	WORK TELEPHONE		CELL PHONE		

IV. BILLING INFORMATION

Social Security Num	ber:	r	Vledica	ire Number	:	Part A: _		Part B:
Medicaid Number: _				Medica	aid Applicat	ion Pending: Y	es	No
Insurance Company	:				Policy	Number:		
Long-term Care Inst	ırance Poli	cy: Yes		No	CT Part	nership Policy?	Yes	No
Name of Agent / Insu	ırance Con	npany:						
Policy Number:						Telephone:		
Do you receive Medi	care from a	a Disability?	Yes _	N	0			
Have you received P	hysical The	erapy, Occupa	tional '	Therapy or	Speech The	erapy Services cov	ered b	ру
Medicare Part B in t	he past yea	r? Yes		No	If so,	which facility:		
Applicant's Total As	<u>sets</u>			<u>A</u>	pplicant's T	otal Income		
Certificates of Depos	sit \$	`		So	ocial Securit	y	\$	
Mutual Funds	•••••			Po	ension	• • • • • • • • • • • • • • • • • • • •		
Securities				A	nnuities	• • • • • • • • • • • • • • • • • • • •		
Cash (Include all Checking			Interest					
& Savings Account).	•••••			_ D	ividends			
Value of House, if ov	vned by ap	plicant						
Applicant's equity (o	wnership)	in house \$		M	iscellaneous	s		
Does spouse reside in	house? Y	es No						
Other Real Estate	····· –			To	otal	\$ _		
Miscellaneous								
Total Assets	\$_			Life Insu	ance Policy	$r(\mathbf{s})$		
Less Total Liabilities			Total Cash Surrender Value \$					
Net Total Assets	····· –			Total Val	ue of Trust	Funds \$		
Do you anticipate a	applying fo	or Medicaid?		Yes	No			
If yes, when do you	anticipat	e you will app	ply?					
Cifta Tuonafona of	A ===4= ===	J Tuomafona 4	T		T a4:41	him last 60 mantl	.	
Gifts, Transfers of Type of Transfer	Value	To Whom		rrevocable dress	rust with	Relationship		te of Transfer
						F		
							-	
	1	1						

Person responsible for p	payment of account: Name:		
Relationship:	Telephone: Home	Work	
Address:	Town:	State:	Zip:
Person to receive inquir	ries about waiting list placement: Name:		
Address:	Town:	State:	Zip:
✓ THE FOLI	LOWING ITEMS ARE REQUIRED TO	PROCESS THE A	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 applica	ble	
this application. If request a credit reporting the results. All persons, in dealing or Vernon Manor Has individuals, for the	nnsfers of assets to an irrevocable trust with necessary, I authorize the above stated nur- ort and that, if such report is requested, I will and or making any agreement with the manage Health Care Center thereby agree to look solutions, demanal hedged that none of the management individations.	rsing facility to conta ll be notified and give gement of Mancheste lely to the Facility its ads or obligations acc	er Manor Health Care Centerly, and not the management roungs to such persons; and
Signed:		Date:	
Applicant For Facility Use Only	t or Responsible Party		
Person Conta	octed Date		<u>Comment</u>