PARSONAGE COTTAGE SENIOR RESIDENCE

A Connecticut Licensed Residential Care Home
88 PARSONAGE ROAD
GREENWICH, CT 06830
(203) 869-6226

Application for Admission

Please Print

Applicant's Name_____**Telephone**_____
(First) (Middle) (Last) (Maiden)

Address_____
(Street) (City) (State) (Zip code)

How Long?_____ **Religion** _____
(Yrs/mths)

Date of Birth _____ **Age**_____ **Sex**_____ **Social Security #:**_____

Nearest Relative/Responsible Party_____ **Relationship**_____
Address_____
Work Telephone_____ **Home Telephone**_____

Two persons to contact in case of an emergency:

1. **Name**_____
   Relationship_____
   Address_____
   Telephone_____
2. **Name**_____
   Relationship _____
   Address_____
   Telephone_____

Family Information:

Marital Status: Single___ Married____ Widowed____ Name of Spouse _____

Children	Name	Address	Work & Home tel #
1.			
2.			
3.			
4.			

Does the applicant have a living will? **Yes_____ No_____**
Does the applicant have a health care agent? **Yes_____ No_____**
(If yes, please attach a copy)

Power of Attorney? Yes____ No____ **Conservator? Yes____ No_____**
(If yes, please attach a copy)

Medicare #_____ Prescription Ins._____

Medicaid #_____ Medigap/other Ins._____

Has the applicant applied for Title XIX/Medicaid assistance? Yes_____ No_____
If yes, please list your workers name and telephone number_____
_____

Military Service:

Did the applicant serve in the military? **Yes _____ No_____**
Did your spouse serve in the military? **Yes _____ No_____**
If yes, please list branch of service and serial #_____

Health History:

Physician's Name _____Telephone_____
Physician's Address_____

Dentist's Name_____Telephone_____
Dentist's Address_____

Has the applicant ever been a resident of any other home or institution? Yes_____ No_____
If "*yes*", give the name and address_____

Has the applicant been hospitalized within the last 12 months? **Yes_____ No_____**
If "*yes*", when and why? _____

Is applicant being followed by a psychiatrist? Yes_____ No_____
(If yes, please include the following)

Name_____ Telephone_____
Address_____

Hearing: **Normal _____** **Impaired _____** **Deaf_____ Hearing aide L_____R_____**
Speech: **Normal _____** **Impaired _____**
Vision: **Normal _____** **Impaired _____** **Eyeglasses_____**
Orientation: **Lucid _____** **Forgetful _____** **Confused at Times_____**

Activities of Daily Living:

Ambulation:	**Independent_____**	**Walker _____**	**Cane _____**
Ability to bathe self:	**Independent_____**	**Some Assist _____**	**Other _____**
Ability to dress self:	**Independent_____**	**Some Assist _____**	**Other _____**
Ability to feed self:	**Independent_____**	**Some Assist _____**	
Bladder Continence	**Always_____**	**Occasional _____**	**Never_____**
Bowel Continence	**Always_____**	**Occasional _____**	**Never_____**

Medication Administration:

Can the applicant self medicate? Yes: _____ No:_____
Self medicate under supervision? Yes: _____ No:_____

Please list all medications:

Name:	**Dosage**	**Frequency**
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		

Use reverse side if needed

Applicants Financial Information

Income:

Social Security	**$_____/mo.**	**Source_____**
Pension	**$_____/mo.**	**Source_____**
Annuity/Mutual	**$_____/mo.**	**Source_____**
Interest/Dividends	**$_____/mo.**	**Source_____**
Veteran's Benefits	**$_____/mo.**	**Source_____**
Trust	**$_____/mo.**	**If "*yes*", please provide a copy**
Other	**$_____/mo.**	**Source_____**

Assets:	**Individually Owned**	**Jointly Owned**	**None**	**Value**
Own Home	_____	_____	_____	**$_____**
Other Property	_____	_____	_____	**$_____**
Stocks/Bonds	_____	_____	_____	**$_____**
Mutual Funds	_____	_____	_____	**$_____**
IRA's/Keoughs	_____	_____	_____	**$_____**
Life Insurance	_____	_____	_____	**$_____**
Funeral Arrangements	_____	_____	_____	**$_____**
Other	_____	_____	_____	**$_____**

In the past 24 months, has the applicant sold, given away [as gifts] or transferred assets of any kind [i.e. motor vehicle, stocks, bonds, cash] for less than fair market value?
Yes_____ No_____
If "*yes*", please list all such transactions in excess of $1,000._____

Bank Accounts:
Include certificates of Deposit

Owner(s) of Account _____Present Balance $_____
Bank Name_____Address_____
Bank Account Number _____

Owner(s) of Account_____ Present Balance $_____
Bank Name_____Address_____
Bank Account Number _____

Owner(s) of Account_____Present Balance $_____
Bank Name_____Address_____
Bank Account Number _____

Applicant's Signature/Responsible Party **Print Name** **Date**

Do you give Parsonage Cottage permission to use your photos in marketing materials?

Applicant's Signature/Responsible Party **Print Name** **Date**

Education & Activities:

Highest Grade Completed _____ Former Occupation_____

Membership in Organizations _____

Leisure Actilvities/Hobbies_____

Special Interests and Skills_____

Burial Arrangements:

Funeral Director_____

Name **Address** **Telephone**

Please list special considerations (i.e. cremation, organ donations, special services, etc.)

COMPLIANCE INFORMATION (OPTIONAL)

The following information is needed for compliance with government selection requirement and for Equal Opportunity Housing reports. It will be detached when your application is filed and the information on it will not be considered in the selection process.

Sex: Male_____ Female_____

Describe yourself in terms of one of the following groups:

___White (not of Hispanic origin) **___Black (not of Hispanic origin)** **_____Hispanic**

___ Asian or Pacific Islander **___American Indian or Alaskan Native**

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88 PARSONAGE ROAD GREENWICH, CT 06830
T: 203.869.6226 F: 203.625.9367
www.parsonagecottage.org

AUTHORIZATION FOR RELEASE OF INFORMATION

RESIDENT'S NAME: _____ DATE OF BIRTH: _____

I hereby authorize the release of all medical information, to Parsonage Cottage Senior Residence. This includes all health care professionals, hospitals, laboratory and diagnostic results. Please release all information which may be requested regarding my past or present condition and treatment rendered therefore.

I hereby authorize full disclosure between Parsonage Cottage Senior Residence and The Department of Social Services of the State of Connecticut, of all information pertinent to my admission and recertification process.

This release will remain in effect/valid during residency and expires upon discharge.

Applicant's Signature: _____ Date: _____

Signature of Person Completing Form: _____
(*If not the Applicant*)

Relationship to Applicant: _____ Date: _____

Conservator: _____ Power of Attorney: _____

(If Conservator or Power of Attorney is checked, please attach the appropriate documentation.)