



Application for Admission
Please Print

Applicant's Contact Information

Name: _____
(First) (Middle) (Last) (Maiden)

Address: _____
(Street) (City) (State) (Zip code)

How Long? _____ Telephone #: _____
(Yrs./mths)

Email: _____

Date of Birth: _____ Age: _____ Sex: (M) _____ (F) _____

Marital Status: Divorced _____ Single _____ Married _____ Widowed _____

Name of Spouse: _____

Social Security #: _____ Medicare #: _____

Other Insurance: _____ Medicare Part D: _____

Medicaid #: _____

Has the applicant applied for Title XIX/Medicaid assistance? Yes _____ No _____

If so, what programs are they currently on: _____

Please list your worker's name and telephone number: _____

Does the applicant have a living will? Yes _____ No _____

Does the applicant have a health care agent? Yes _____ No _____

Power of Attorney? Yes _____ No _____ Conservator? Yes _____ No _____

If yes, contact information: _____

(Please attach a copy of each)



Equal Housing
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Nearest Relative/Responsible Party

Name: _____ Relationship: _____

Address: _____

Work Telephone: _____ Home Telephone: _____

Email Address: _____

Contact information in case of an emergency:

1. Name _____	2. Name _____
Relationship _____	Relationship _____
Address _____	Address _____
_____	_____
Telephone _____	Telephone _____
Email: _____	Email: _____

Family Information:

Children	Name	Address	Work & Home tel #
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1.

2.

3.

4.

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 # _____

Has the applicant applied for Veterans Benefits? Yes _____ No _____

Health History:

Primary Care Physician's Name _____

Address _____

Telephone _____ Fax _____

Specialist Physician's Name _____

Address _____

Telephone _____ Fax _____

Dentist's Name _____

Address _____

Telephone _____ Fax _____

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 _____

Address _____

Telephone _____ Fax _____

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 _____

Hearing: Normal _____ Impaired _____ Deaf _____ Hearing aid L _____ R _____

Speech: Normal _____ Impaired _____

Vision: Normal _____ Impaired _____ Eyeglasses _____

Orientation: Lucid _____ Forgetful _____ Confused at Times _____

Do you Smoke? Yes ____ No ____

Allergies: Yes ____ No ____ If yes, please list _____

Please list all medications:

Name:	Dosage	Frequency
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2.

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17.

Medication Allergies: Yes ____ No ____ If yes, please list _____

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:

	Individual	Joint	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 _____

Please list all Bank Accounts:

Include certificates of Deposit

Owner(s) of Account _____ Present Balance \$ _____

Bank Name _____ Account Number _____

Address _____

Owner(s) of Account _____ Present Balance \$ _____

Bank Name _____ Account Number _____

Address _____

Owner(s) of Account _____ Present Balance \$ _____

Bank Name _____ Account Number _____

Address _____

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

Yes _____ No _____

Education & Activities

Highest level of education completed _____

Former Occupation _____

Membership in Organizations _____

Leisure Activities/Hobbies _____

Special Interests and Skills _____

Pre Need Burial Arrangements:

Yes _____ No _____

Funeral Parlor Name: _____

Address

Telephone #

Applicant's Signature/Responsible Party

Print Name

Date

*All applicants may be subject to a background check

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



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.)

Authoriz. 7/15



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1d



RATES

Inclusive of all services:

- Market Rate: **\$ 157.81 Daily**
 \$ 4,800.00 Monthly

- Financial Assistance:

Is available for qualifying individuals under the "Aid to the Aged, Blind and Disabled" program set by the Department of Social Services of CT.

SERVICES PROVIDED

Inclusive in the monthly rate:

- Three (3) meals and snacks serviced daily
- Weekly housekeeping
- Laundering of linen and towels
- 24-hour staff availability
- Assistance with bathing, dressing, personal laundry
- Storage, supervision, ordering and delivery of medication
- Sprinkler and smoke alarm in each room
- 24-hour emergency call system in each room and bath
- Free Cablevision (Family Cable)
- Recreation program
- Social Worker available

