Colonial Health & Rehab Center of Plainfield, LLC
16 Winsor Avenue, Plainfield, CT 06374 TEL. (860) 564-4081 FAX (860) 564-1472

FACILITY APPLICATION

APPLICANT IS SEEKING:

Check if you desire to be added to Waiting List for future Long Term Placement [ ]
(Applicants interested in future Long-Term Placement can be added to the waiting list upon substantial completion of the entire application and will be noted with a formal receipt number)

Long Term Placement _____ Receipt No: _____
(Applicants must substantially complete the entire application to be added to the waiting list)

Email Address (Waiting List Notifications): _____

APPLICANT INFORMATION

1. Name: _____(Maiden) _____
2. Address: Street _____
   City _____
   State _____ Zip code _____

   Phone (Home) _____ (Work) _____ (Cell) _____
3. Source of Referral: _____
4. Date of Birth: _____ Age: _____ Place of Birth: _____
5. Social Security Number: _____- _____- _____
6. Sex: _____ Marital status: _____
7. Religion: _____ Church / Synagogue: _____
8. U.S. Citizen: ____ Yes ____ No Naturalized: _____ Yes _____ No
9. Spouse: _____ Phone: _____
10. Responsible Party Name: _____ Relationship: _____
    Address: Street _____
    City: _____
    State: _____ Zip Code: _____

    Phone (Home) _____ (Work) _____ (Cell) _____
11. Second Contact Person Name: _____ Relationship: _____
    Address: Street _____
    City _____
    State _____ Zip Code: _____

    Phone: (Home) _____ (Work) _____ (Cell) _____

12. Lifetime Occupation: _____

13. Level of Education: __ Grammar School ___ High School ____ Some College ____ College Grad ____

HOSPITALIZATION: (If applicable)

1. Date of Admission: _____ Hospital: _____
2. Admitting Diagnoses: _____

_____

_____

3. Attending Physician: _____
4. Current Illness: _____
5. Significant Past Medical or Psychiatric History: _____

_____

_____

SOCIAL AND FUNCTIONAL INFORMATION:

1. Applicant's present/former living arrangements: _____
2. Smoker? _____ Yes _____ No
3 Primary Language: _____ Secondary: _____
4. Discharge Plan / Goals:

_____

_____

_____

EMPLOYMENT INFORMATION:

1. Are you currently working full or part-time? ____ Yes ___ No

2. Is your spouse currently employed full or part-time? ____ Yes ___ No

3. If yes to 1 or 2, how many employees do you or your spouse's employers have? _____

4. Retirement Date: _____ Spouse's Retirement Date: _____

PAYMENT SOURCE:

1. Are you covered under an employer group health plan through your current or former employment of your spouse or other family Member? ____ Yes ____ No

   If yes:
   a. Insurance Company:_____
   b. Name of Insured: _____
   c. Patient's Relation to Insured: _____
   d. Claim or Policy Number: _____
   e. Name of Group Plan: _____
   f. Group Identification: _____
   g. Employer Name: _____
   h. Employer Location: _____

2. Is this hospitalization or treatment caused by an automobile accident or other accident?
   _____ Yes _____ No

   If yes:
   a. Auto Medical / Liability
      Insurance Company: _____
   b. Name of Insured: _____
   c. Claim or Policy Number: _____
   d. Date of Accident: _____

3. Is this hospitalization or treatment caused by an accident or illness that occurred at work?
   _____ Yes _____ No

   If yes:
   a. Workers Compensation: _____
   b. Claim or Policy Number: _____
   c. Name of Employer: _____
   d. Employer Location: _____

4. Are you entitled to black lung medical payment? _____ Yes _____ No

5. Are services to be paid by a government program such as research grant?
   ____ Yes ____ No

6. Do you have a free service card from the department of veteran's affairs?
   ____ Yes ____ No

7. Have you enrolled in a Medicare Advantage Plan? ___ Yes ____ No

   a. Policy Number: _____
   b. If Yes: (Chekck)

Anthem	[ ]	
United Healthcare	[ ]	
Care Partners of CT	[ ]	
Wellcare	[ ]	
Connecticare	[ ]	
Aetna	[ ]	
Other	[ ]	Specify:_____

8. Are you covered by Traditional Medicare? Yes_____ No_____

   If yes:
   a. Policy Number: _____
   b. Part A ___ Yes ____ No
   c. Part B ___ Yes ____ No
   e. Secondary Coverage (Medex, Medi-Gap) _____ Yes ____ No
      If yes, Coverage _____ Number _____
   f. If no secondary coverage, will you be able to pay the co-pay amount of
      $_____beginning on day 21? _____ Yes ____NO

If under 65 years of age:

a. Have you received a kidney transplant? ____Yes ____No
Date_____

b. Have you received maintenance kidney dialysis treatment? ____Yes ____No
Date Started: _____

9. Have you waived Medicare Benefits to participate in:

a. An HMO ____Yes ____No
b. Hospice ____Yes ____No

10. Are you covered by Medicaid / Title XIX? ____Yes ____No

If yes:

a. Medicaid Number _____

b. If there are any bank books, who holds them?
Relation to Patient: _____
Name: _____
Street: _____
City: _____
State: _____Zip: _____
Phone: (H)_____(W)_____(C)_____

c. Who currently receives the applicant's social security and/or retirement and other sources of income?
Relation to Patient: _____
Name: _____
Street: _____
City: _____
State: _____Zip: _____
Phone: (H) _____ (W) _____(C) _____

d. Would you permit the nursing facility to handle the applicant's personal funds?
____Yes _____No

e. Would you permit the nursing facility to become the payee for income that must be applied to the applicant's care? ____Yes ____No

f. Have you applied for Medicaid? ____Yes ____No

11. Will you be paying by private funds now or in the future (after Medicare expiration)?
____Yes ____No

If yes:
a. Who should we bill? Name: _____
Street: _____
City: _____
State: _____Zip: _____
Phone: (H) _____ (W) _____(C) _____

12. Do you have insurance coverage for long-term care? ____Yes ____No

If yes:
a. Name of Company or Plan: _____

b. Policy Number: _____

12. Are you or your spouse a veteran? _____Yes ____No

If yes:
a. Service Branch: _____

b. Service Number: _____

SIGNATURE:

Applicant is: competent incompetent (please circle one)

If incompetent, decisions are made by:
(please check appropriate line)

Conservator _____
Guardian _____
Healthcare Agent _____
POA _____
Durable POA _____
Other _____ _____
(please specify title)

Name of person making decisions for applicant:
_____
Relationship to Patient:

Street: _____

City: _____

State: _____Zip: _____

Phone: (H) _____ (W) _____(C) _____

The answers given by me in completing this application (and supplement as applicable) are, to the best of my knowledge, true and complete.

_____ _____
Applicant's Signature Witness

_____ _____
Authorized person completing form on Applicant's behalf Relationship to Applicant

Street: _____

City: _____

State: _____ Zip: _____

Phone: (H) _____ (W) _____ (C) _____

Date: _____

Colonial Health & Rehab Center of Plainfield, LLC
16 Winsor Avenue, Plainfield, CT 06374 TEL. (860) 564-4081 FAX (860) 564-1472

FINANCIAL DISCLOSURE

1. LIST ALL INCOME THAT YOU OR YOUR SPOUSE/SIGNIFICANT OTHER HAVE. IF NONE, CHECK "NONE"

INCOME	SELF	SPOUCE/ OTHER	NONE
Social Security	$		
Railroad Retirement	$		
Veteran's Benefits	$		
Worker's Compensation	$		
Disability Benefits	$		
Unemployment Compensation	$		
Interests and Dividends	$		

Other Income: (i.e. rental property, relative's help, etc. Please explain.)

ASSETS

2. LIST ALL ASSESTS THAT YOU OR YOUR SPOUSE/SIGNIFICANT OTHER HAVE. IF NONE, CHECK "NONE".

ASSETS	SELF	SPOUSE /OTHER	JOINT	NONE
Cash on Hand	$	$	$	
Property Other Than Home	$	$	$	
Own Home	$	$	$	
Stock – Bonds	$	$	$	
Car (Year and Make)	$	$	$	
Pending Law Suit	$	$	$	
Pending Inheritance	$	$	$	
Trailer (Year and Make)	$	$	$	
Life Use (please circle)	Yes No			

3. IF YOU OR YOUR SPOUSE/SIGNIFICANT OTHER HAVE MONEY IN THE BANK, INCLUDING JOINT ACCOUNTS, COMPLETE THE FOLLOWING:

NAME OF BANK	ACCOUNT NAME	ACCOUNT #	PRESENT BALLANCE	LARGEST BALANCE IN PAST 60 MONTHS

Does Applicant have irrevocable Funeral Trust? ____Yes ____No

Amount Paid $ _____ Date: _____

Funeral Director Name: _____

Address: _____

_____

4. HAVE YOU, IN THE PAST 60 MONTHS, TRANSFERRED OR GIVEN REAL ESTATE, PERSONAL PROPERTY, CASH OR OTHER ASSETS TO SOMEONE ELSE?
   _____Yes ____No

   IF YES:

   EXPLAIN BELOW WHAT WAS SOLD, TRANSFERRED OR GIVEN TO SOMEONE ELASE, BY WHOM, TO WHOM, THE DATE, THE VALUE OF THE PROPERTY AT THAT TIME, AND WHAT WAS RECEIVED IN RETURN.

   _____

   _____

   _____

5. ARE YOU COVERED BY LIFE INSURANCE OR DEATH BENEFIT?
   _____Yes _____No

   IF YES:

NAME OF INSURED	NAME OF COMPANY	POLICY NUMBER	DATE POLICY TAKEN OUT	NAME OF PERSON PAYING PREMIUMS	AMOUNT OF INSURANCE	CASH VALUE
					$	$

6. WHAT METHOD OF PAYMENT WIL BE USED TO COVER YOUR STAY?
   Private pay or self pay? _____Yes ____No
   Medicare? _____Yes ____No Medicare # _____
   Medicaid? _____Yes ____No Medicaid # _____

Colonial Health & Rehab Center of Plainfield, LLC
16 Winsor Avenue, Plainfield, CT 06374 TEL. (860) 564-4081 FAX (860) 564-1472

BACKGROUND MEDICAL INFORMATION

1. **Date of Admission Desired:** _____

2. **Medical Information:**

Diagnosis:
Medications:

3. **Personal Care:** (Please check all that apply)

BATHING	DRESSING	FEEDING	MOBILITY	AMBULATORY /TRANSFER SUMMARY
Self	Self	Self	Indep.	
Assist	Assist	Assist	Assist of 1	
Dependent	Dependent	Dependent	Assist of 2	
		NG Tube	Bedbound	
		G Tube	Walker	
			Cane	

4. **Diet:** _____ 5. **Height:** _____ 6. **Weight:** _____

7. **Continence:**
Continent _____Yes _____No
Incontinent _____Yes _____No

8. **Communication and Visual Problems:**
Speech _____Yes _____No
Hearing _____Yes _____No
Vision _____Yes _____No

9. **Skin Integrity:**
Intact ___Yes ____No
Reddened / Open Areas ___Yes ____No

10. **Mental Status:**
Forgetful ____Yes ____ No
Alert ____Yes ____No
Confused ____Yes ____No
Unresponsive ____Yes ____No

11. **Behavior:**

_____ Abusive / Assaultive (Physical or Verbal)
_____ Unsafe or Unhealthy Hygiene/Habits (i.e., public health risks)
_____ Wandering
_____ Threats to Health/Safety (i.e., poor judgment)

Explain problem behaviors and frequency of occurrences: _____
_____
_____

12. **Substance Abuse:**

Alcohol ____Yes ____No Drugs ____Yes ____No

Explain problem behaviors and frequency of occurrences: _____

_____
_____

13. **Psychiatric History:**

In patient hospitalization: ____Yes ____No
If yes, please explain: _____
_____
_____

14. **Allergies:**

List _____

15. **Will the applicant need physical, occupational or speech therapy?**
_____

16. **Has the applicant had any prior long term care experience?**
If yes, please explain.
_____

17. **Has the applicant had any care services?** _____Yes ____No
If yes, what agency?
_____

18. **Does the applicant have a burial contract?** ____Yes ____No
If yes, please complete.
Name of Funeral Home: _____
Amount: _____
Cemetery plot: _____

If no arrangements made, funeral home preferred: _____
_____

19. **Family's reaction to nursing home placement?** _____
_____

20. **Was nursing home placement discussed with patient?** ____Yes ____No
If no, why not? _____
_____

If yes, patient's reaction: _____
_____

21. **Family providers:**
Dentist: _____
Podiatrist: _____
Ophthalmologist/Optometrist: _____
Pharmacy: _____

22. **Current Physician:** _____

23. **Physician of Choice:** _____

Dr. Joseph Alessandro

ARTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION IN CONNECTION WITH ELIGIBILTY FOR ADMISSION AND CONTINUED STAY AT COLONIAL HEALTH & REHAB CENTER OF PLAINFIELD, LLC

To: All providers of medical and dental services or supplies and their representatives, the Medical Information Bureau, INC. or other organizations, all insurers, medical or hospital service plans, prepaid health plans.

For purpose of determining eligibility for admission and continued optimal medical care, I authorize you to furnish Colonial Health & Rehab center of Plainfield, LLC or its representatives performing business or legal functions, any information available about my medical history, condition and treatment.

I authorize Colonial Health & Rehab Center of Plainfield, LLC to re-disclose such information to an attending physician for treatment purposes and to any person who has an authorization specifically permitting the re-disclosure, and as may be permitted or required by law.

I hereby authorize Colonial Health & Rehab Center of Plainfield, LLC to disclose medical information to Medicare, insurance carriers, and other third-party payor as is necessary and/or required by law to facilitate payment of claims in my behalf. I further authorize payment to be made directly to Colonial Health & Rehab Center of Plainfield, LLC for the services provided.

I agree that this authorization is valid throughout my stay at Colonial Health & Rehab Center of Plainfield, LLC.

I know that I have a right to ask for and receive a copy of this authorization.

Signed this _____ day of _____ 20_____.

_____
Signature of Applicant

_____
Signature of Responsible Party

_____
Relationship if other than Applicant