Villa Maria
Nursing & Rehabilitation

"Outstanding rehabilitation is our specialty
Exceptional nursing care is our promise."

Application for Admission

Dear Friend,

Once you have completed our brief application for admission and return the form below to our facility you will be considered for admission. If any information is omitted, this admission request will not be considered.

All of the information provided will be kept strictly confidential. If you have any questions, please feel free to contact the Administration Office for assistance.

Thank you for considering Villa Maria Nursing and Rehabilitation.

Sincerely,

Cindy Disco

Owner/Administrator

Villa Maria Nursing & Rehabilitation
20 Babcock Avenue, Plainfield, CT 06374
Phone (860)564-3387 Fax (860)564-6651
www.villamarianursing.com

VILLA MARIA NURSING & REHABILITATION COMMUNITY, INC.
APPLICATION FOR ADMISSION

PERSONAL INFORMATION:

Applicant Name _____ Sex____ Date of Birth _____

Home Address _____ Home Phone # _____
_____

Marital Status _____ Social Security # _____

Are you a legal resident of the United States? Yes or No

MEDICAL INFORMATION

Type of placement requested: □ Rehabilitation □ Respite □ Long Term Care □ Hospice

Information is being provided by _____/_____
Relationship to applicant?

Contact # _____ Email: _____

Applicant is now at _____ Anticipated Admission Date _____

Physician _____

Diagnosis _____

Current Medications _____

Treatment being requested _____

Height _____ Weight _____ Does applicant smoke? Yes or No

Is applicant able to ambulate [walk]? _____Yes _____No

Please Choose: ____Walker ____ Cane ____ Wheelchair

Most Recent Hospital Stay Dates:
Facility _____From _____ to _____
Facility _____From _____ to _____

Other Nursing Facility Stay Dates:
Facility _____From _____ to _____
Facility _____From _____ to _____

Cats reside in this facility and other animals may visit do you have any allergies to animals?
Yes or No

FINANCIAL INFORMATION

Who will be responsible for financial decisions? _____
Contact # _____ Relationship_____
Address: _____

Who will be responsible for medical decisions? _____
Contact # _____ Relationship_____
Address: _____

Please indicate the available source of payment the applicant will use to pay for the cost of care and provide claim numbers where applicable and copies of claim cards:

Primary Insurance Name _____ Ins. # _____
Secondary Insurance Name _____ Ins. # _____
Additional Insurance Name _____ Ins. # _____

Are there other possible sources of payment such as: □ Black Lung Benefit □ Workers Compensation □ Insurance due to an Automobile Accident □ Government Research or □ A Partnership-Approved for Long-Term care insurance policy?

FACE PAGE of Long-Term Policy must state: "This policy has been pre-certified under the Connecticut Partnership for Long-Term Care and provides Medicaid Asset Protection"

Applicant's Own Income: $ _____/month_____
List each source separately and use reverse side if needed.

Does the applicant receive income from or have any interest in any trust? Yes or No
If yes, please describe_____

Spouse' Own Income: $ _____/month_____
List each source separately and use reverse side if needed

Does the spouse receive income from or have any interest in any trust? Yes or No
If yes, please describe _____

Other (rental property, stocks and bonds, trusts, etc.) Explain.
_____
_____

Please list all bank accounts the applicant owns either individually or jointly.

Account Name	Name of Bank	Current Balance
_____	_____	_____
_____	_____	_____

Please indicate if the applicant owns any property either individually or jointly:

Location	Who Owns It?	Approx. Value
_____	_____	_____
_____	_____	_____

Was this real estate your home prior to entering the nursing home? Yes or No

Is your spouse now living in the home? Yes or No

Does the applicant have a "Life use" of any real estate (any ownership interest, in full or in part, for his or her lifetime, or the right to occupy property for his or her lifetime)? Yes or No

Is the applicant covered by life insurance? Yes or No
If yes, please provide the name of the company _____ and cash value _____

Does the applicant have a prepaid funeral contract? Yes or No
If yes, please provide the name of the funeral home _____ and the amount paid _____

Within sixty (60) months prior to the date of this application, has the applicant or the applicant's spouse given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind? Yes or No

If so please describe fully all such gifts or transfers in excess of $1,000, including the asset transferred, names, addresses and relationship of the person to whom the gift or transfer was made, and the value of the gift or transfer.

_____
_____

Within the past 60 months, has the applicant or applicant's spouse created any trusts or placed funds or any other assets in a trust that already existed? Yes or No.
If yes, please explain and provide a copy of the trust instrument.

_____
_____

I certify that I have fully investigated the applicant's financial records and 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 trust created or transfers of assets to any trust that the applicant or his or her spouse has made.

_____	_____	_____	_____
Applicant’s Signature	Date	Responsible Party Signature	Date

Thank you for considering Villa Maria Nursing & Rehabilitation