# WESTCOTT-WILCOX APPLICATION FOR ADMISSION

## GENERAL INFORMATION

Name of Applicant: _____

Home Address: _____ Home Phone # (____) _____

Date of Birth_____/_____/_____ Marital Status_____ Sex_____

Religion/Parish: _____ Birthplace: _____

Responsible Party for **Financial Decisions**:
Name: _____ Address: _____
Home Phone: _____Cell: _____Work: _____
Relationship To Applicant: _____ POA ____ Conservator of Person ____

Primary person to contact in case of emergency (**Medical Decisions**):
Name: _____Address: _____
Home Phone: _____Cell: _____Work: _____
Relationship To Applicant: _____ POA ____ Conservator of Person ____

Alternate contact person:
Name: _____Address: _____
Home Phone: _____Cell: _____Work: _____
Relationship To Applicant: _____ POA ____ Conservator of Person ____

If applicant is in a medical facility at present, please complete the following:
Name of Facility: _____ Date of Admission_____/_____/_____
Address of Facility: _____

## MEDICAL INFORMATION

Primary Care Physician: _____Address/Phone:_____

Primary Diagnosis: _____Allergies: _____

Reason For Placement: _____Recent Hospitalizations: _____

Height: _____ Weight: _____

**Current Medications:**

| Medication Name: | Dosage: | Frequency: |
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Other Physicians providing Care: Dentist, Ophthalmologist, Specialists etc.

Type of Physician:_____Name:_____Phone: _____
Type of Physician:_____Name:_____Phone: _____
Type of Physician:_____Name:_____Phone: _____

Dietary Requirements: _____
Food Dislikes: _____

What assistance is required with personal care (Please check, if applicable):

Bathing: _____ Medication. Reminders: _____ Dressing: _____
Personal Hygiene: _____ Other (please explain): _____
Bladder Incontinence: _____ Bowel Incontinence: _____
Does the applicant wear pads or garments for incontinence? _____
**Vision:** Good ____ Fair ____ Poor ____ **Hearing:** Good ____ Fair ____ Poor ____
**Ambulation:** Good ___ Fair ___ Poor ___ **Does applicant use a:** Cane ___ Walker ___ Wheelchair ____

Does the applicant have (please check all that is applicable):
Living will: ___ Advanced Directives: ___ POA: ___ Conservator: ___ Other (please explain below): ___
(Please provide paperwork upon submission of Application for Admission)

Has the applicant been receiving any medical care from a related or non-related party while living in their home? ❑YES ❑NO

## FINANCIAL INFORMATION (Please provide a copy of cards)

Social Security #:_____ Medicare #:_____
Medicare Co-Pay #:_____ Medicare Supplement #:_____
Medicaid (State Medical Assistance) #: _____

Does the applicant have an application pending for State Medical Assistance (Title 19)?
❑YES ❑NO If yes, please indicate: Date application submitted: _____/_____/_____
District Office: Case Worker:_____
Is the applicant a Veteran? ❑YES ❑NO Spouse of a Veteran? ❑YES ❑NO
Is the applicant covered by any other medical or hospital insurance? ❑YES ❑NO
Name of Company: _____Identification # _____ Type of Insurance: _____

Do you own a Partnership-Approved Long-Term Care Insurance Policy? (This policy has been pre-certified under the Connecticut Partnership for Long-Term Care and provides Medicaid Asset Protection)? ❑ YES ❑NO If yes, with whom?_____
What is your current ID #_____
Does the applicant own life insurance? ❑ YES ❑NO
If yes, Name of Company: _____
Cash Value $_____ Face Value $_____

Has an irrevocable burial account been established? ❑ YES ❑NO
Name of Funeral Home: _____Amount $_____

**Income - Applicant, and spouse if applicable**
Please list all income including but not limited to:
Social Security, Pensions, VA Benefits, Workman's Compensation, Annuities, Rental Income.

| Source | Amount | Payable to Whom |
|---|---|---|
| Supplemental_____ | _____ | _____ |
| Security Income?_____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Cash Assets**
Please list all assets including but not limited to:
Savings Accounts, Checking Accounts, Stocks, Bonds, C.D.'s, Trusts, Annuities, etc.

| Name of Institution | Account # | Present Balance | Largest Balance in the past 36 months | Who is listed on the account? |
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**Real Estate**
Does applicant own any real estate? ❑ YES ❑ NO

| **Description of Property** | **Approximate Value** | **Names on Deed** |
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Are there any liens or mortgages against the property? ❑ YES ❑ NO
If so, in the amount of $_____ payable to_____

Is anyone other than the applicant living in the home? ❑ YES ❑ NO

**Transfer of Assets**-Has the applicant transferred, sold, or given real estate, personal property, cash or any other assets in the past 60 months? _____

| Item Transferred | Value | To Whom | Date |
|---|---|---|---|
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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 that the applicant has made within the sixty (60) months prior to the date of this application.

_____ _____ _____ _____
Applicant Signature Date Responsible Party Signature Date