



HEBREW HEALTH CARE
for health, for life

Date: _____

Name: _____

Inquiry List # _____ as of _____

Dear Family Member:

To actively pursue admission to the Hebrew Home & Hospital, the applicant, a family member, or a legally responsible person must fully and accurately complete and return to this office the enclosed *Pre-Admission Application*. Upon receipt of the completed application, the applicant's name will be placed on our Waiting List. Once placed on the Waiting List, we strongly recommend that an appointment be made with the Social Work Services Department to discuss the admission process, as well as the applicant's medical, nursing and emotional needs. At the same time the applicant and/or family member will meet with the Director of Admission to determine the source of payment for care (Medicaid, Medicare, Private Insurance or Self-pay).

If you have any questions, please do not hesitate to call this office at (860) 523-3960.

We look forward to hearing from you again, and working together toward a timely admission to the Hebrew Home & Hospital.

Sincerely,

Jonas R. Steiner, MSW, LCSW
Vice President, Admissions & Social Work Services

IMPORTANT NOTICE TO ALL APPLICANTS FOR ADMISSION

These documents are provided for informational purposes only. They are not intended to serve as an offer of admission to the Hebrew Home & Hospital. Our clinical staff will be reviewing your application. We will contact you once a final admission decision has been made.

Sincerely,

Jonas R. Steiner

Vice President, Admissions & Social Work Services

The Hebrew Home and Hospital, Inc. [OR] Community Outreach Program for the Elderly, Inc., will not exclude from participation in, deny the benefits of, or otherwise discriminate against any eligible person in any of its programs, including employment. All of our programs are open to eligible persons regardless of their race, color, religious creed, sex, age, national origin, ancestry, marital status, sexual orientation, mental retardation or past/present history of mental disorder, learning disability or physical disability. If you have a complaint about unfair treatment, please bring it directly to our President, Bonnie Gauthier, at (860) 523-3892.

STATE OF CONNECTICUT REGULATION OF
 CONNECTICUT STATE DEPARTMENT OF SOCIAL SERVICES
 CONCERNING NURSING HOME DISCRIMINATION AGAINST APPLICANTS FOR ADMISSION

SECTION 17-311-205

You have contacted this nursing home and indicated a desire to be admitted as a patient to this facility. Because of this, you have been sent this pre-assessment application and your name has been placed on our dated list of application inquiries list.

Please find enclosed this facility's written application form. As soon as you substantially complete and return this form to the facility, your name will be placed on our waiting list for admission to the facility. Your name will only be placed on our waiting list after you substantially complete and return this written application form to us.

Pre-assessment Application Sheet

Personal Data					
Name:					
Last	First	Middle	Maiden	Application date:	
Present address (must include zip code):			Number of Years	Phone Number	
Is applicant living alone? <i>If no, with whom do they live?</i>			Does applicant have home health aide/companion?		
Previous address:			Number of Years	Phone Number	
Date of Birth:	Place of Birth:	Social Security #	Date of Arrival in USA	Place of Arrival in USA	
Education:		Occupation before retirement:		Date of retirement:	
Marital Status: Please check one: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated					
Name of Spouse:			Marriage dates: (from - to)		
Are you a veteran?	Spouse of a veteran?	Veteran number:			
Do you have any of the following: <i>Please check all that apply:</i>					
<input type="checkbox"/> Living Will Conservator/guardian?		<input type="checkbox"/> Health Care Directive		<input type="checkbox"/> Power of attorney for health care? <input type="checkbox"/>	
Name, address, zip code and phone number of Conservator of Person					
Name, address, zip code and phone number of Conservator of Estate					
Name, address, zip code and phone number of Power of Attorney					
Name, address, zip code and phone number of Applicant's physician					

Interested Relatives and/or Parties

Name, address, zip code, relationship to applicant, occupation and home and business telephones

Name, address, zip code, relationship to applicant, occupation and home and business telephones

Name, address, zip code, relationship to applicant, occupation and home and business telephones

Name, address, zip code, relationship to applicant, occupation and home and business telephones

Insurance Data

Medicare Number	Medicaid Number	Pending Medicaid Approval?	Application Date	Applying Agency	Name of State Worker

Name of insurance	Insurance policy #

Name of insurance	Insurance policy #

Medical Data/Nursing HistoryApplicant's Living Arrangements: *Please check all that apply:*
 Lives Alone Has Home Health Aide/Companion Lives with Family Member?

Whom? _____

 Lives with Other? Whom? _____

 Resides in a Nursing Home? Name & Address: _____
Functional Needs *Please check all that apply:**The Applicant requires assistance/is independent in the following areas:*

Bathing:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance	Dressing:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
Grooming:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance	Toileting:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
Cooking:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance	Housekeeping:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
Shopping:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance	Budgeting:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
Banking:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance	Walking:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
Transferring:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance	Eating:	<input type="checkbox"/> Independent	<input type="checkbox"/> Needs Assistance
Continent of Bladder:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Continent of Bowel:	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Hospitalizations *Please list name of hospital, dates of admission, reason for hospitalization and address if out of area:*

Medical Data/Nursing History *continued*

If applicant has been seen by a psychiatrist, please list name, address, date and reason for consultation.

If applicant has been seen by a neurologist, please list name, address, date and reason for consultation.

If applicant has been treated for drug/alcohol abuse, please list name, address, and dates.

Religious Data

Religion	Synagogue/Church Affiliation (<i>name & address</i>)
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Preferred funeral home (*name, phone number & address*)

Cemetery (*name & address*)

Hebrew Names (*if applicable*)

Client:

Client's Father:

Client's Mother:

Reason for Application

Please supply all appropriate information for the admission interview. This information is needed before application can be processed for admission into the Hebrew Home & Hospital.

Photocopies of the following are required:

Power of Attorney; Living Will; Durable Power of Attorney for Health Care; Health Care Agent; Conservatorship; Medicare Card; Social Security Card; All Insurance Cards

ADMISSION FINANCIAL RECORD

Name _____ Social Security No. _____
 Address _____ Medicaid No. _____
 Telephone _____

Current Monthly Income

Social Security Amount \$ _____
 Pension \$ _____
 Trust Fund-Principal Amount OR Monthly Income Amount \$ _____
 Other \$ _____

Capital Assets (indicate holding jointly held) \$ _____
 Cash On Hand \$ _____
 Other Assets \$ _____

Bank	Address	Account No.	
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____

Stocks and Bonds _____ \$ _____
 _____ \$ _____
 _____ \$ _____

Real Estate (Owned and Mortgages) _____ \$ _____
Total: \$ _____

Insurance Company	Policy No.	Beneficiary	
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
_____	_____	_____	\$ _____
	Type:		Total: \$ _____

Assets Disposed of in the last three years \$ _____
 Type \$ _____
 _____ \$ _____

Power of Attorney: Held by Whom? _____
 Guarantor (Name and Address) _____
 Debts and Obligations _____ \$ _____
 _____ \$ _____
Total: \$ _____

**THE HEBREW HOME DOES NOT REQUEST ASSETS BE TURNED OVER AS A CONTINGENCY FOR ADMISSION.
 ALL FIGURES MUST BE SUPPORTED WITH COPIES OF BANK STATEMENTS, PASSBOOKS AND FINANCIAL STATEMENTS.**

**THE HEBREW HOME AND HOSPITAL
ONE ABRAHMS BOULEVARD, WEST HARTFORD, CT 06117
DEPARTMENT OF ADMISSIONS AND SOCIAL WORK SERVICES
(860) 523-3960**

Please supply all appropriate information requested below for the admissions process. This information is necessary for admission to the Hebrew Home and Hospital

THIS IS ONLY A CHECKLIST - DID YOU PROVIDE THE FOLLOWING ON THIS APPLICATION?

Current Physician – Full name, address, zip code and telephone number.

Financially Responsible Person full name, address, zip code, home and business telephone numbers.

(Copy) Power of Attorney, (Copy) Conservatorship

Emergency Contact Person full name, address, zip code, home and business telephone numbers.

Copy of Medicare card, Social Security card and copies of other insurance cards.

Hospitalizations – Name and address of hospital including town, state, zip code, dates of admission or exact year, and physician, if known.

* Financial Status – Complete financial information sheet.

(Copy) Health Care Directive, Living Will, Durable Power of Attorney for Health Care, Health Care Agent, if any.

Burial Arrangements – Cemetery Name and Mortuary/Funeral Home (if available)

Religious Affiliation

Synagogue or Church

Hebrew Names – Applicant's Name, Applicant's Mother Name and Applicant's Father Name (If applicable)

Other interested individuals – Full names, addresses, zip codes and home and business telephone numbers.

Other Relevant information (specify)

* The State of Connecticut requires a 36-month financial history for persons applying for Medicaid. See enclosed information sheet.