Masonicare

# APPLICATION FOR RESIDENCY
## Long-Term Care or Residential Care (Wright Residence)

**HOW DO I APPLY?** Please complete the following sections of the application:

**Section A:** **Personal Information** (one for each applicant)

**Section B:** **Financial Information** (one per couple)

Please provide supporting financial documentation including:

- a recent tax return – first two summary pages
- summary pages for investments
- current bank statements

**Section C:** **Additional Information** (one for each applicant)

**Section C-2:** **Miscellaneous Information** (one per applicant)

**Section D:** **Physician's Summary**

- Bring this to your primary care doctor(s) for completion

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Please return the application to:

| | | |
|---|---|---|
| **Masonicare Health Center:** | Long-Term Care<br>Residential Care (Wright Residence) | Admissions Department<br>P.O. Box 70<br>Wallingford, CT 06492<br>203-679-5901 |
| **Masonicare at Newtown:** | Long-Term Care | Admissions Department<br>P.O. Box 5505<br>Newtown, CT 06470<br>203-426-5847 |

One of our admissions coordinators may contact you if additional information is necessary to further evaluate your needs and process your application. **Your name will be placed on our Waiting List only after you substantially complete and return the application.** Per Connecticut State Law, if you are offered admission and decline, your name shall remain on our Waiting List. Feel free to contact us regarding the status of your application.

**Important Information When Applying to**
**Masonicare Health Center or Masonicare at Newtown Nursing Homes**

WHEN YOU CONTACT THIS NURSING HOME AND INDICATE A DESIRE FOR ADMISSION TO THIS FACILITY, YOU WILL BE ISSUED A RECEIPT INDICATING THE DATE AND TIME OF YOUR INITIAL REQUEST. YOUR NAME WILL BE PLACED ON OUR DATED LIST OF APPLICATIONS OR INQUIRY LIST.

PLEASE FIND ENCLOSED THIS FACILITY'S WRITTEN APPLICATION FORM. AS SOON AS YOU SUBSTANTIALLY COMPLETE AND RETURN THE 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.

Masonicare

# Application for Residency

*Residential Care:* Leslie G. Wright Residence
*Long-Term Care:* Masonicare Health Center – Wallingford / Masonicare at Newtown

## SECTION A PERSONAL INFORMATION

### APPLICANT INFORMATION

Name: _____
*Last* *First* *Middle* *Maiden*

Address: _____
*Street* *Unit #* *City*

_____ Date of Birth ____/____/____
*State* *Zip* *Month* *Day* *Year*

Phone: (_____)_____ ☐ Male ☐ Female

Cell Phone: (_____)_____ Religion _____

Email: _____ Church _____

Marital Status: ☐ Married ☐ Single ☐ Widow/Widower

Spouse Name: _____ Date of Spouse's Death: _____

### PERSON TO NOTIFY IN CASE OF EMERGENCY

**Primary Contact:**

Name: _____ Relationship: _____

Address: _____

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

Email: _____

**Secondary Contact:**

Name: _____ Relationship: _____

Address: _____

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

Email: _____

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# SECTION A PERSONAL INFORMATION

## ADVANCE MEDICAL DIRECTIVES

Do you have a **Living Will**? ☐ Yes ☐ No **(Please attach a copy)**

Do you have a **Power of Attorney**? ☐ Yes ☐ No **(Please attach a copy)**

Name: _____ Phone: (_____) _____

Address: _____

Do you have a **Health Care Agent/Representative**? ☐ Yes ☐ No **(Please attach a copy)**

Name: _____ Phone: (_____) _____

Address: _____

Do you have a **Conservator or Guardian**? ☐ Yes ☐ No **(Please attach a copy)**

Name: _____ Phone: (_____) _____

Address _____

What is his/her relationship to you? _____

## INSURANCE INFORMATION

**Primary Medical/Medicare Insurance** **(Please attach copy of card)**

Company Name: _____ Policy# _____

Address: _____

**Secondary** **(Please attach copy of card)**

Company Name: _____ Policy# _____

Address: _____

**Prescription Insurance** **(Please attach copy of card)**

Company Name: _____ Policy# _____

Address: _____

**Long-Term Care Insurance** **(Please attach copy of card)**

Company Name: _____ Policy# _____

Address: _____

Are you eligible for Medicare? ☐ Yes ☐ No

**Soc. Sec. #:** _____ **Medicare #:** _____

## MEDICAID (Title 19)

Do you receive **Medicaid (Title 19) assistance?** ☐ Yes ☐ No If yes, Medicaid ID# _____

If you have applied for Medicaid and now await approval:

Date applied: _____ What District Office? _____

Name of your Case Worker: _____ Phone: _____

If denied - list date: _____ Reason: _____

**Signature:** _____ **Date:** _____

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## SECTION B – FINANCIAL INFORMATION

*Please provide supporting documentation including: recent tax return (first two summary pages), current bank statements, and investment statements (summary pages).*

Name(s): _____

**Assets:**

**Real Estate** $_____

**Other Real Estate** $_____

| **Savings and Investments:** | **Current Balance** | **Survivor** |
|---|---|---|
| Cash/Checking Accounts | $_____ | %_____ |
| Savings/CDs | $_____ | %_____ |
| Money Market Accounts | $_____ | %_____ |
| Stocks/mutual funds | $_____ | %_____ |
| Bond/bond funds | $_____ | %_____ |
| Life Insurance | $_____ | $_____ |

**TOTAL ASSETS:** $_____

**Liabilities:**

Mortgage $_____

Other $_____

**TOTAL LIABILITIES:** $_____

**TOTAL NET WORTH:** $_____

| **Net Monthly Income:** | *Person 1* | *Person 2* |
|---|---|---|
| Social Security | $_____ | $_____ |
| Pension/retirement | $_____ | $_____ |
| Other | $_____ | $_____ |

**TOTAL MONTHLY INCOME:** $_____

## Long-Term Care Insurance

Do you have **Long-Term Care Insurance**? Yes ☐ No ☐
*If yes, please complete the following:*

| | *Person 1* | *Person 2* |
|---|---|---|
| Benefit Period (Time limit on payments) (Generally – 1, 2, 5 years or lifetime) | | |
| Elimination Period – Waiting time before payments start (ex. 30, 60, 90 days) | | |
| Daily benefit in Assisted Living | $ | $ |
| Annual Premium (current dollars) | $ | $ |

## Other Assets

Do you have a **pre-paid funeral contract**? Yes ☐ In the amount of: $ _____ No ☐

Name of Funeral Home Address City State Zip

Do you have a **pre-paid cemetery plot**? Yes ☐ In the amount of: $ _____ No ☐

Name of Cemetery Address City State Zip

Have you or your spouse **sold, transferred or given away** any bank accounts, stocks, real estate or any other assets during the last 60 months (5 years)?

Yes ☐ No ☐ If yes, please explain. (Use another sheet of paper if necessary.)

Do you or your spouse have any **lawsuits or legal action** pending?

Yes ☐ No ☐ If yes, describe:

## Motor Vehicle Information

Do you own a car, truck, camper, recreational vehicle or other **vehicle**? No ☐ Yes ☐

Do you plan to take the vehicle(s) to a Masonicare facility with you? No ☐ Yes ☐

Owner(s): _____ Type of vehicle: _____

Make: _____ Model: _____ Year: _____ Mileage: _____

Owner(s): _____ Type of vehicle: _____

Make: _____ Model: _____ Year: _____ Mileage: _____

## Acknowledgement and Verification

The Department of Social Services policy states that any applicant may be fully or partially ineligible for Medicaid Assistance (Title 19) if, within 60 months prior to the date of application for Medicaid Assistance, he/she has made an assignment, transfer, or other disposition of any assets or other resources for less than fair market value for the purposes of qualifying for Medicaid Assistance. Original bank books, savings accounts, annuity/trust fund statements or copies thereof, including verification of all withdrawals for 60 months prior to admission, may be required at the time of permanent admission.

Except as noted on this application, I have not made an assignment, transfer, or other disposition of any assets or other resources for less than fair market value within the past 60 months. I understand that, as a condition of admission, I must maintain eligibility for all State and Federal financial or medical assistance programs, including Medicaid, from the date of this application forward. I further understand that I must demonstrate that I have a continuous source of payment.

I certify and declare, under penalties of false statement, that the foregoing information is complete, accurate, and true. I further understand that the omission or falsification of any information provided on this application, or at any subsequent date, may result in the automatic denial of this application and/or may result in my subsequent discharge from the care of Masonicare.

I authorize any bank where I have or have had an account, or any firm or individual with whom I may have done business, to furnish financial information to Masonicare, upon request. It is understood that such information shall be used to verify information in connection with my application for admission to Masonicare, and is confidential. I further understand and agree that a copy of this statement may be used in lieu of the original.

Signed: _____ Relationship: _____

Witness: _____ Date: _____

This application must be signed by the applicant (the future resident) or by the applicant's Power of Attorney or Conservator, and witnessed.

NOTE: If this application is signed by the Power of Attorney or Conservator, a copy of the Power of Attorney or the Conservator Appointment must be attached to this application.

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FOR DOUBLE-SIDED COPYING

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## SECTION C-1 AUTHORIZATION RELEASE

**FOR ANY INPATIENT HOSPITAL STAY**
**AUTHORIZATION FOR RELEASE AND USE OF PROTOECTED HEALTH INFORMATION**

I, the undersigned patient, resident, client or legal representative, hereby authorize the listed Masonicare affiliate to receive use or disclose health information including, if applicable, information relating to the diagnosis or treatment of mental illness, drug and/or alcohol abuse and confidential HIV related information regarding:

Patient Name _____ Date of Birth _____/ _____/ _____

Name of Hospital _____

The information may be disclosed to and used by the following:

_____
Masonicare Affiliate Phone

_____
Address City/State Zip

The purpose of this disclosure or use is for the following reason:

☐ Continuing Care

☐ Other (please specify) _____

_____

_____

The date(s) of service and the type(s) of information to be used or disclosed are as follows:

Date(s) of Treatment: _____

☐ Discharge Summary

☐ Other (please specify) _____

_____

I understand that I may cancel this authorization at any time by notifying Masonicare's Privacy Officer in writing, but, if I do so, it will not affect actions Masonicare took before it received the cancellation. I understand that, under applicable law, the information disclosed under this authorization may be subject to further disclosure by the recipient and thus may no longer be protected by federal privacy regulations. I understand that I may inspect or copy the information to be used or disclosed and that Masonicare my receive compensation for copying fees related to the use/disclosure of my health information under this authorization. I agree that a copy of this authorization will be as valid as the original. This authorization will be valid for a period of one year from the date below. I understand that under applicable law the information disclosed under this authorization may be subject to further disclosure by the recipient and thus, may no longer be protected by federal privacy regulations. I understand that my treatment or continued treatment by Masonicare and its affiliates is in no way conditioned upon whether or not I sign this authorization and that I may refuse to sign it.

_____ _____
**Patient Signature (or legally authorized representative*)** Date

**If legal representative, legal document is required*

Any information released by Masonicare and its affiliates to authorized persons is subject to the following notices:

**Psychiatric Information:**
*In the event that information released constitutes confidential psychiatric information protected under Connecticut law:* this information has been disclosed to you from records whose confidentially is protected by state law. State law prohibits you from making further disclosure of it or of using it for any purpose other than that indicated above without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law.

**Drug and Alcohol Abuse Information:**
*In the event that information released is protected by the HHS Confidentiality of Alcohol and Drug Abuse Patient Records regulations:* This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate to prosecute any alcohol or drug abuse patient.

**HIV-Related Information:**
*In the event that information released constitutes confidential HIV-related information protected under Connecticut law:* This information has been disclosed to you from records whose confidentiality is protected by state law. State law prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by said law. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Patient Name Printed _____ Your relationship to Patient ** _____

**** Note, if you are signing as the legally authorized representative of the patient, please indicate your relationship to the patient here (this should demonstrate your legal authority to consent to health care for the patient.)**

## SECTION C-2 MISCELLANEOUS INFORMATION

### Military

Are you a military veteran? ☐ Yes ☐ No

Is/was your spouse a military veteran? ☐ Yes ☐ No

What is your claim number? _____ Your spouse's? _____

### Masonic Affiliation

Are you or any member of your family a member of a Masonic organization? ☐ Yes ☐ No

What is the name and relationship of that family member? _____

What Lodge/Chapter/Court do you/they belong to? _____

**Please return this form to:**

**Masonicare Health Center**
**Attn: Admissions Department**
**P.O. Box 70**
**Wallingford, CT 06492**

**or**

**Masonicare at Newtown**
**Attn: Social Services Department**
**P.O. Box 5505**
**Newtown, CT 06470**

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## SECTION D – PHYSICIAN'S SUMMARY

**Note to Physician:** The person whose name appears below is an applicant for admission to Masonicare. A current health report *is required* as part of the admission process.

Applicant's Name: _____

Date of Birth: _____ Age: _____ Sex: Male ☐ Female ☐

Address: _____

City/State/Zip: _____

**Please complete this form and send to: (check one)**

| | | |
|---|---|---|
| ☐ **Masonicare Health Center**<br>***Long-Term Care***<br>**Admissions Department**<br>P.O. Box 70<br>Wallingford, CT 06492<br>Tel: 203-679-5901<br>Fax: 203-679-6900 | ☐ **Masonicare Health Center**<br>***Wright Residence***<br>**Admissions Department**<br>P.O. Box 70<br>Wallingford, CT 06492<br>Tel: 203-679-5901<br>Fax: 203-679-6900 | ☐ **Masonicare at Newtown**<br>***Long-Term Care***<br>**Admissions Department**<br>P.O. Box 5505<br>Newtown, CT 06470<br>Tel: 203-364-3211<br>Fax: 203-364-3153 |

Purpose of Assessment: ☐ Pre-Admission Date of Examination: _____

**Primary diagnosis** + ICD-9 code: _____

Secondary: + ICD-9 code: _____

☐ PPD ☐ Chest X-Ray Date Received: _____ Result: ☐ None/Inactive ☐ Active/Quiescent

If contraindicated, state reason: _____

**Physical Health:**

Weight _____ Height _____ Blood Pressure _____

Pulse _____ Respiration _____

| **Functional Abilities:** | Good | Fair | Poor | Additional Information |
|---|---|---|---|---|
| Walking (with/without device) | ☐ | ☐ | ☐ | |
| Hearing (with/without device) | ☐ | ☐ | ☐ | |
| Vision (with/without corrective lenses) | ☐ | ☐ | ☐ | |
| Speech | ☐ | ☐ | ☐ | |

| **Activities of Daily Living:** | Self | Assistance Required | Additional Information |
|---|---|---|---|
| Bathing | ☐ | ☐ | |
| Personal Hygiene | ☐ | ☐ | |
| Dressing | ☐ | ☐ | |
| Toileting/Toilet Hygiene | ☐ | ☐ | |
| Transferring (bed to chair/chair to bed) | ☐ | ☐ | |
| Oral Hygiene/Denture Care | ☐ | ☐ | |
| Eating at meal time | ☐ | ☐ | |

| **Medication Use:** | Yes | No | Additional Information |
|---|---|---|---|
| Does resident administer own medications? | ☐ | ☐ | |
| Does resident require medication reminder? | ☐ | ☐ | |
| Does resident require supervision when taking medications? | ☐ | ☐ | |

| **Lifestyle:** | Yes | No | |
|---|---|---|---|
| Does the resident smoke? | ☐ | ☐ | |
| Does the resident consume alcohol? | ☐ | ☐ | |

**Mental Health:**

Cognitive Status ☐ Alert ☐ Short-term memory concerns
☐ Confused ☐ Long-term memory concerns

Evidence of Dementia ☐ Yes ☐ No Type if known: _____

History of Mental Illness/Health Problems: ☐ Yes ☐ No

Diagnosis, if known _____

**Medical History:** *If yes, give details. Use additional sheet if necessary.*

| | | | | | |
|---|---|---|---|---|---|
| Arthritis | ☐ Yes | ☐ No | Hematological Disorders | ☐ Yes | ☐ No |
| ASHD | ☐ Yes | ☐ No | Hepatic Pathology | ☐ Yes | ☐ No |
| Asthma | ☐ Yes | ☐ No | Hepatitis B | ☐ Yes | ☐ No |
| Cancer | ☐ Yes | ☐ No | High Cholesterol | ☐ Yes | ☐ No |
| Cataracts | ☐ Yes | ☐ No | Hypertension | ☐ Yes | ☐ No |
| Cerebral Arteriosclerosis | ☐ Yes | ☐ No | Incontinence | ☐ Yes | ☐ No |
| Cerebral Vascular accident | ☐ Yes | ☐ No | Neurological Disease | ☐ Yes | ☐ No |
| Colitis | ☐ Yes | ☐ No | Osteoporosis | ☐ Yes | ☐ No |
| Developmentally Disabled | ☐ Yes | ☐ No | Pancreatitis | ☐ Yes | ☐ No |
| Diabetes | ☐ Yes | ☐ No | Pulmonary Disease | ☐ Yes | ☐ No |
| Diverticulosis | ☐ Yes | ☐ No | Renal Pathology | ☐ Yes | ☐ No |
| Epilepsy/Seizures | ☐ Yes | ☐ No | Stroke | ☐ Yes | ☐ No |
| Family or other history of HIV | ☐ Yes | ☐ No | TBC | ☐ Yes | ☐ No |
| Glaucoma | ☐ Yes | ☐ No | | | |

Other: _____

Details: _____

_____

Allergies: ☐ Yes ☐ No Explain: _____

**Review of Systems:**

Integumentary

Respiratory

Cardiovascular

Gastrointestinal

Genitourinary

Musculoskeletal

Neurological

Endocrine

Pain

**Prescription Medications:**

| Medication | Dosage | Frequency by time | Additional Information |
|---|---|---|---|
| | | | |
| | | | |
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**OTC Medications:**

| Medication | Dosage | Frequency by time | Additional Information |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Other Supplements/Treatments: (i.e. Holistic/Natural/Homeopathic/Massage etc.)**

| Medication | Dosage | Frequency by time | Additional Information |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

**Special Treatments and Procedures, not listed above** (Narrative):_____

_____

_____

**Routine Orders:**

Routine Lab Work ☐ Yes ☐ No

Test(s) _____ Frequency _____

Test(s) _____ Frequency _____

Test(s) _____ Frequency _____

Podiatry Services ☐ Yes ☐ No Frequency _____

Annual Flu Vaccine ☐ Yes ☐ No Date last received _____

Other _____

**Specific Diet Requirements** ☐ Regular ☐ No added salt ☐ Diabetic

☐ Other _____

**IMPORTANT**

In your medical opinion, is the resident considered chronic and stable? ☐ Yes ☐ No

Does the applicant have a signed Do Not Resuscitate Order (DNR)? ☐ Yes ☐ No

Would you recommend the applicant for a campus-sponsored fitness program? ☐ Yes ☐ No

Are there any restrictions to consider?

Explain: _____

Physician's Name _____ *(type or print)*

Physician's Address _____ City/State/Zip _____

Telephone/FAX _____

Signature of Physician _____ Date _____

**AUTHORIZATION FOR RELEASE OF MEDICAL**

I hereby authorize the release of medical information contained in the report of the examination of:

Applicant Name:_____

***Signature:*** _____ **Date:** _____