



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

Please return the application to:

Masonicare Health Center:	Long-Term Care	Admissions Department P.O. Box 70 Wallingford, CT 06492 203-679-5901
	Residential Care	Wright Residence Counselor P.O. Box 70 Wallingford, CT 06492 203-679-5402

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

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.

Application for Residency

Masonicare Health Center: Long-Term Care
Residential Care (Leslie G. Wright Residence)



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: _____

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:** _____

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:

	<i>Person 1</i>	<i>Person 2</i>
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

**FOR ANY INPATIENT HOSPITAL STAY
AUTHORIZATION FOR RELEASE AND USE OF PROTECTED 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 may 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.

<p>_____ Patient Signature (or legally authorized representative*)</p>	<p>_____ Date</p>
<p><i>*If legal representative, legal document is required</i></p>	

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 confidentiality 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 Health Center
Wright Residence Counselor
P.O. Box 70
Wallingford, CT 06492

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)

<input type="checkbox"/> Masonicare Health Center <i>Long-Term Care</i> Admissions Department P.O. Box 70 Wallingford, CT 06492 Tel: 203-679-5901 Fax: 203-679-6900	<input type="checkbox"/> Masonicare Health Center <i>Wright Residence</i> Attn: Wright Residence Counselor P.O. Box 70 Wallingford, CT 06492 Tel: 203-679-5402 Fax: 203-679-6953
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Purpose of Assessment: Pre-Admission Date of Examination: _____

Primary diagnosis + ICD10 code: _____

Secondary: + ICD10 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)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing (with/without device)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Vision (with/without corrective lenses)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Speech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

Activities of Daily Living: Self Assistance Required Additional Information

Bathing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Personal Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Toileting/Toilet Hygiene	<input type="checkbox"/>	<input type="checkbox"/>	_____
Transferring (bed to chair/chair to bed)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Oral Hygiene/Denture Care	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eating at meal time	<input type="checkbox"/>	<input type="checkbox"/>	_____

Medication Use:	Yes	No	Additional Information
Does resident administer own medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does resident require medication reminder?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does resident require supervision when taking medications?	<input type="checkbox"/>	<input type="checkbox"/>	_____

Lifestyle:	Yes	No	
Does the resident smoke?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Does the resident consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hematological Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
ASHD	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatic Pathology	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High Cholesterol	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cerebral Arteriosclerosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Incontinence	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cerebral Vascular accident	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Neurological Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Colitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Osteoporosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Developmentally Disabled	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pancreatitis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Pulmonary Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diverticulosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Renal Pathology	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy/Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Family or other history of HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	TBC	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No			

Other: _____

Details: _____

Allergies: Yes No Explain: _____

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:** _____