SAINT MARY HOME
PART OF THE MERCY COMMUNITY

In-House Use ONLY
Date Received

2021 Albany Avenue, West Hartford, CT 06117
860.570.8200

APPLICATION FOR ADMISSION

As soon as you substantially complete and return this application form to Saint Mary Home, 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.**

Date: _____ Referred By: _____

GENERAL INFORMATION			
Applicant's Name:		Current Location:	
Home Address:			
City:	State:	Zip:	Phone: ( ) Cell Phone: ( )
Birthplace:	Birthdate: / /		Age:
Sex:	Social Security #:		Citizen of:
Veteran: ☐ Yes ☐ No	Spouse of Veteran: ☐ Yes ☐ No		Branch:
Veteran's #:	Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced		
Spouse's Name:	Father's Name:		Mother's Maiden Name:

Responsible Party/Emergency Contact (1)	**Responsible Party/Emergency Contact (2)**
Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____
Home Phone: ( ) _____	Home Phone: ( ) _____
Work Phone: ( ) _____	Work Phone: ( ) _____

** The responsible party does not personally guarantee or serve as a surety for payment. If the responsible party has control or access to the resident's income and/or assets, the responsible party agrees that these funds will be used for the resident's welfare, including but not limited to making prompt payment for care and services rendered to the resident.

Competency of Applicant:

☐ Applicant **is competent** and making his or her own decisions.

☐ Applicant is **not competent;** therefore, decisions are made by: ☐ POA ☐ Conservator Estate/Person

Name: _____ Type of legal appointment:_____

Address: _____

Primary Phone Number:
☐ Bus. ☐ Home ☐ Cell
( ) _____

Secondary Phone Number:
☐ Bus. ☐ Home ☐ Cell
( ) _____

E-mail Address: _____

Do you currently live alone? ☐ Yes ☐ No Do you receive assistance at home? ☐ Yes ☐ No

Educational Level: Occupation (before retirement):

Leisure pursuits and community involvement: _____

Have you ever lived in retirement housing? ☐ Yes ☐ No Skilled nursing facility? ☐ Yes ☐ No

If so, where/when? _____

Reason for Application: ☐ Post–Acute ☐ Alzheimer's/dementia ☐ Respite Care

☐ Long–Term Skilled Care: ☐ Hospice Care

MEDICAL INFORMATION

Physician: Primary Phone Number: ( )

Hospital Preference: Primary Phone Number: ( )

Pharmacy Preference: Primary Phone Number: ( )

Other Physician/Specialty: Primary Phone Number: ( )

Current/Recent Illness: _____

_____

Past Medical History: _____

_____

Have there been any hospital stays or emergency room visits in the past year? ☐ Yes ☐ No

Have there been any skilled nursing facility stays in the past five years? ☐ Yes ☐ No

Do you currently receive assistance or intervention from (check all that apply):

☐ Hospice
Name of Agency: _____

☐ Home Care/Visiting Nurse:
Name of Agency: _____

Do you have a Living Will? ☐ Yes ☐ No Do you have a Health Care Proxy? ☐ Yes ☐ No

Name, phone number, and address of preferred funeral home: Primary Phone Number:

_____

RELIGIOUS DATA

Religion: _____ Name and Address of Church/Place of Worship: _____

_____

MEDICAL INSURANCE INFORMATION

In order to process your application, determine the proper level of care, and complete State required pre-admission screening, the following information is required:

Medicare #:	Other Insurance: _____
Medicaid #:	Identification #:_____
Pending Medicaid Approval: ☐ Yes ☐ No	Address: _____
Application Date:	_____
Case Worker's Name:	Phone Number: ( ) _____

FINANCIAL RECORD

Current Monthly Income: **Amount**

Social Security	$
Pensions	$
Dividends	$
Interest	$
Trust Fund-Principal or Monthly Income	$
VA Benefits	$
Capital Assets: ☐ Individually Held ☐ Jointly Held	$
Cash on Hand:	$

Other Assets:

Bank Name	Bank Address	Account #	Account Balance
			$
			$
Total			$

Stocks and Bonds:

	Value
	$
	$
Total	$

Real Estate ***(If asset is jointly held, please provide name of joint owner):***

	Value
	$
	$
Total	$

Life Insurance Policies:

Insurer	Policy Number	Policy Type	Beneficiary	Value
				$
				$
				$
Total				$

VA Insurance Policies:

Insurer	Policy Number	Policy Type	Beneficiary	Value
				$
				$
				$
Total				$

Assets Disposed of in the Last Five Years (Include Type of Asset):	Value
	$
	$
	$
Total	$

Transfer of Assets

Within **five years** 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 for less than fair market value?

☐ Yes ☐ No

If so, describe fully all such gifts or transfers in excess of $1,000.00 including the asset transferred, names, addresses, and relationship of the person to whom the gift or transfer was made, and value of the gift or transfer.

_____

_____

_____

Within 60 months (five years) prior to the date of this application, has the applicant or the applicant's spouse:

- created any trusts? ☐ Yes ☐ No
- placed funds or any other assets in a Trust that already existed? ☐ Yes ☐ No

If yes, please describe and provide a copy of the Trust instrument.

I certify that the information contained in this application is true and accurate to the best of my knowledge.

I further certify 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 $1,000.00 within the past five years and any trust created or transfers of assets to any trust made by the applicant or his or her spouse within the 60 months prior to this application.

_____ _____

Signature of Applicant Date

_____ _____

Signature of Authorized Representative Relationship to Applicant

The Mercy Community

THE McAULEY | SAINT MARY HOME

CONSENT AND RELEASE TO BE PHOTOGRAPHED, INTERVIEWED OR PUBLISHED

I, _____ hereby grant Mercy Community Health, Inc. and its affiliates permission to use my name, interview information, and any photographic portraits or video footage taken of me. I understand that Mercy Community Health, Inc.'s possible uses may include, but are not limited to, print and broadcast news: newspaper, magazines, radio, television, video, websites, and social media.

I understand that this consent allows Mercy Community Health, Inc. and its affiliates to copyright this material for use and re-use.

I have read the foregoing and fully understand the contents thereof. This consent and release shall be binding upon me and my heirs, legal representatives, and assigns.

Name: _____ Date: _____

(Please Print)

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

Signature of Person Providing Consent to be photographed, interviewed and published

Relationship of person named above if signing as a parent or legal guardian for a minor

Signature of Witness _____

Mercy Community Health, Inc. • 2021 Albany Avenue •West Hartford, CT 06117 • 860.570.8200
Saint Mary Home • The McAuley

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