Suffield House
REHABILITATION AND HEALTHCARE CENTER

LONG-TERM CARE APPLICATION

Date: _____ Requested Move-In Date: _____

I. DEMOGRAPHICS

Name: _____ DOB: _____ SSN: _____

Address: _____

Primary Contact: _____

Address: _____

Phone Number: _____

Email: _____

Is there a Power of Attorney or Conservatorship in place? Yes / No

If yes, please attach paperwork:

Name: _____

Address: _____

Phone: _____

Primary Language: _____

Current Living Situation: _____

II. MEDICAL INFORMATION

PCP Name: _____ PCP Phone Number: _____

Home Care Agency: _____

Please provide a brief description of primary medical diagnoses and care needs:

_____

_____

_____

III. INSURANCE INFORMATION

Primary Insurance:

Name: _____

Policy Number: _____

Secondary Insurance (if applicable):

Name: _____

Policy Number: _____

Tertiary Insurance (if applicable):

Name: _____

Policy Number: _____

Do you have a Long-Term Care insurance policy? Yes / No

If Yes:

Name: _____

Policy Number: _____

Will this be private pay? Yes / No

If yes, please complete the attached financial information worksheet and return with the application

IV. FINANCIAL INFORMATION

INCOME

INCOME TYPE	FREQUENCY: MONTHLY/OTHER	AMOUNT
Social Security		$
Social Security Supplemental		$
Veteran's Payments		$
Civil Service Authority		$
Other Retirement		$
Rents, Dividends, Interest		$
Royalties		$
Other		$
	TOTAL	$

REAL ESTATE

Does resident own a home? Yes / No

If yes, what is the value: _____

Address: _____

City/State/Zip: _____

Rental Property: _____

Is property mortgaged? Yes / No

If yes, what is the amount: _____

Has resident transferred any assets in the last 5 years? Yes / No

Asset: _____ Value: _____ Date of Transfer: _____

Asset: _____ Value: _____ Date of Transfer: _____

RESIDENT ASSETS

Checking Accounts $_____

Savings Accounts $_____

Accounts Closed in Last 60 Days $_____

Certificate of Deposit $_____

Savings Bonds, Annuities, Stocks $_____

Signer on Other Accounts $_____

Safe Deposit Box $_____

Resident Trust Funds $_____

Retirement Funds	$_____
Cash Not in the Bank	$_____
Life Insurance	$_____
Burial Plots	$_____
Promissory/Mortgage Notes	$_____
Trusts	$_____
Life Estates	$_____
Oil, Gas, Mineral Rights	$_____
Livestock	$_____
Work Equipment	$_____
Autos, Trucks, Recreational Vehicles	$_____

Does resident own or share ownership of anything not noted above? (If yes, describe)

_____

_____

Agreement for Residents Receiving/Applying to Receive Government Assistance:

In accordance with the rules and regulations of the Social Security Administration and the state's department of Human Services:

1. The Resident & Resident Representative hereby agree that all income received by or for said Resident in excess of $_____ per month shall be paid to the facility and applied to said residents monthly bill. The estimated Resident Liability is $_____ based on the financial information provided. Upon final eligibility approval, any charges to the Resident Liability will be communicated & adjusted accordingly.
2. The Resident and Resident Representative hereby agree that in the event said resident is denied governmental assistance that the resident will be personally responsible for any unpaid charges, such charges to be computed using the facility's standard private rate.
3. The Resident & Resident Representative hereby understand that completing this form does not constitute Medicaid approval or denial.
4. An application must be filed with the state's Department of Human Services. Failure to file timely will result in loss of assistance.

I have read and understand the above statements. I certify that the information on this form is true and correct to the best of my knowledge and belief.

_____ _____

Signature Date

_____

Printed Name/Title

To Be Completed By Admissions Office Upon Receipt:

Date Received: _____ Receipt Number: _____