APPLICATION FOR ADMISSION

You have contacted this Facility and indicated a desire to be admitted as a patient to this facility. Because of this, you have already been issued a receipt indicating the date and time of your initial request and your name has been 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 application form to us.

Saint Joseph Living Center participates in the Medicaid (Title 19) program and has a provider agreement with the State of Connecticut to provide care and services to Medicaid assisted residents. Eligibility for Medicaid assistance is determined by the State of Connecticut Department of Income Maintenance, based on each resident's financial resources.

Saint Joseph Living Center also participates in the Medicare (Title 18) program and has a provider agreement with the United States Department of Health and Human Resources to provide care for and services to residents who are eligible for Medicare benefits. Eligibility for Medicare benefits is determined according to the rules established by the Secretary of Health and Human Services, based on the type of care that is needed and if other requirements, such as a prior 3 day hospital stay are met.

Saint Joseph Living Center will provide that no person in the United States on the grounds of race, color, religion, age, sex, sexual orientation or handicap, be denied the benefits or be subject to discrimination under any of our programs, admission policies, training programs, or employment practices.

This is a 120 bed Skilled Nursing Facility. Our current rates are as follows:

	As of July 1, 2015
Semi-Private Room	$415.00 per day
Private Room	$445.00 per day

If you have any questions regarding the admission procedure, please feel free to contact us.

APPLICATION FOR ADMISSION

Applicant's Name: _____Date of App:_____

Address:_____

Telephone #:_____ Soc. Sec.#_____

Date of Birth:_____ Age:_____ Sex:_____

Place of Birth:_____ U.S. Citizen: Yes_____ No_____
Veteran/spouse of: Yes_____ No_____

Marital Status: Married___ Single__ Widowed__ Spouse's name_____

Religious Denomination:_____ Parrish_____

Lifetime Occupation:_____ Primary Language:_____

Mother's Maiden Name:_____ Father's Name:_____

Name of Inquirer:_____ Telephone #:_____

Address:_____

Reason Placement is requested:_____

Type of Stay: Short-term rehabilitation_____ Long-term_____
Hospice_____

Have any Home Care Services been used in the past? Yes_____ No_____
Which Agency?_____

Funeral Home Preference:_____

Have Funeral arrangements been made? Yes_____ No____
Prepaid Account: Yes____ No_____ Irrevocable: Yes____ No____

Where does applicant live now:_____

Has applicant ever been at another facility?_____

Other Persons to Contact (in case of emergency)

Name Address Telephone

_____

_____

_____

Name, Address, and Phone # of current Physician:_____
_____

Does the applicant have a living will? Yes____ No____

Does the applicant have a Power of Attorney? Yes____ No____

Does the applicant have a Health Care Agent? Yes____ No____

Does the applicant have a court appointed Conservator? Yes____ No____

We will need copies of the following prior to admission: Medicare Card, Health Insurance Cards, and, if applicable: Power of Attorney, Appointment of Conservator, Living Will, Health Care Agent.

Copies of these items can be made at the facility at no charge.

I certify that the facts contained in this application are true and complete. I also understand that falsified statements on this application may be grounds to reject admission to Saint Joseph Living Center. I authorize investigation of all statements contained herein and release all parties from liability that may result from furnishing the same.

I authorize Saint Joseph Living Center to obtain any medical information deemed necessary and understand that Saint Joseph Living Center participates in both Medicaid and Medicare programs.

_____ _____

Signature Applicant/Responsible Party Date

FINANCIAL DATA

To process your application, the following information is required. This information is strictly confidential. Your application cannot be processed without this information.

The Name(s) of the person(s) who will be financially responsible for the cost of care:

Name Address Telephone Relationship

_____

_____

_____

How will the stay be financed?

Private funds _____
Insurance: Medicare _____ Long Term Care Insurance _____ Other _____
Medicaid (Title 19) _____ Active: Yes___ No___
Need to apply? Yes ___ No ___ When? _____

FINANCIAL ASSETS INFORMATION SHEET
INTERMEDIATE LEVEL OF DISCLOSURE

Social Security # _ _ _ -_ _ -_ _ _ _ Gross Check Amount $_____

Railroad Retirement #_____ Gross Check Amount $_____

Veterans #_____ Gross Check Amount $_____

Other Pension #_____ Gross Check Amount $_____

How often paid _____ From Whom_____

Other Pension #_____ Gross Check Amount $_____

How often paid_____ From Whom_____

FINANCIAL ASSETS INFORMATION SHEET -CONTINUED

Name and # Shares: Value

STOCKS/BONDS _____ $_____

_____ _____

_____ _____

_____ _____

REAL ESTATE #1 _____Estimated Worth_____

Address

Mortgage Amount $_____Your Interest _____

(life use, own outright or %)

REAL ESTATE #2 _____Estimated Worth _____

Address

Mortgage Amount $ _____Your Interest_____

(life use, own outright or %)

CHECKING/SAVINGS BANK ACCOUNTS:

1. Bank Name _____ Address _____
   Account # _____ Amount $_____
   Joint Account _____Amount $_____With Whom
   _____
   Yes/No

2. Bank Name _____ Address _____
   Account # _____ Amount $_____
   Joint Account _____Amount $ _____ With Whom
   _____
   Yes/No

3. Bank Name _____ Address _____
   Account # _____ Amount $ _____
   Joint Account _____Amount $ _____ With Whom
   _____
   Yes/No

FINANCIAL ASSETS INFORMATION SHEET – CONTINUED

INTEREST IN LIMITED LIABILITY COMPANY (LLC), FAMILY LIMITED PARTNERSHIP (FLP), LIMITED LIABILITY PARTNERSHIP (LLP)? IF YES, DESCRIBE.

ANY OTHER ASSETS NOT LISTED ABOVE?

ANY LAWSUITS THREATENED OR PENDING?

TRANSFER OF ASSETS WITHIN 60 MONTHS:

Describe. Use additional sheet if needed.

Date of Transfer	What Transferred	Value of Transfer	To Whom Transferred
1.			
2.			
3.			
4.			

INSURANCES:

Medicare Part A# _____ **Medicare Part B**#_____

Medicaid # _____

Does the applicant have a **Medicare Supplemental Insurance**? Yes ___ No ___
Name of Insurance _____ Policy # _____

Does the applicant have **Medicare Part D Insurance**? Yes ___ No ___
Name of Insurance_____ Policy # _____

Does the applicant have **Long Term Care Insurance**? Yes ___ No ___
Company Name _____ Please provide a copy of policy.

Does the applicant have **Life Insurance Policies**? Yes ___ No ___
Ins. Co. Name _____ Face Amount $_____
CSU Amount $_____

Irrevocable Burial Account:
Funeral Home _____ Amount $_____
Please provide a copy of arrangements.

FINANCIAL ASSETS INFORMATION SHEET - CONTINUED

Trusts: Describe your interest. Please provide a copy of trust.

May income be used for your benefit? Yes ___ No ___
May principal be used for your benefit? Yes ___ No ___

Name and Address of Trustee: _____

CREATING/FUNDING OF TRUST WITHIN 60 MONTHS

Describe in detail and provide copy of trust.

I affirm that to the best of my knowledge, the information submitted in this Financial Assets Information Sheet is accurate. I understand that misrepresentation is a basis for both resident admission denial and discharge.

_____ _____
Signature of Applicant Date

_____ _____
Signature of person completing form on Applicant's behalf. Date

_____ _____
Signature of Responsible Party Date

_____
Relationship to Applicant

_____
Address & Telephone Number of person signing Home: Work:

We are required by law to obtain from each applicant prior to admission a signed statement showing the applicant's acknowledgment, as to whether this nursing home participates in the Medicaid and Medicare programs, and of our policies regarding advance payments and deposits.

NOTICE OF PROGRAM PARTICIPATION

THIS NURSING HOME PARTICIPATES IN THE MEDICAID (TITLE 19) PROGRAM AND HAS A PROVIDER AGREEMENT WITH THE STATE OF CONNECTICUT TO PROVIDE CARE AND SERVICES TO MEDICAID-ASSISTED RESIDENTS. ELIGIBILITY FOR MEDICAID ASSISTANCE IS DETERMINED BY THE STATE OF CONNECTICUT DEPARTMENT OF INCOME MAINTENANCE.

THIS NURSING HOME ALSO PARTICIPATES IN THE MEDICARE (TITLE 18) PROGRAM AND HAS A PROVIDER AGREEMENT WITH THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES TO PROVIDE CARE AND SERVICES TO PATIENTS WHO ARE ELIGIBLE FOR MEDICARE BENEFITS.

State and Federal law regulations impose the following limitations on the advance payment and deposit requirement of nursing homes:

No nursing home may request an advance payment or deposit from a Medicare beneficiary for any service or supplies covered by Medicare as a condition of admission:

No nursing home may request an advance payment or deposit from a Medicaid recipient as a condition of admission; and

A nursing home may request an advance payment or deposit of up to one thousand five hundred dollars ($1,500.) from an applicant who has applied for Medicaid, provided such payment or deposit is held in an account for the applicant's benefit and returned to the applicant when he is eligible for Medicaid.

THE FOLLOWING ARE THE POLICIES OF SAINT JOSEPH LIVING CENTER REGARDING ADVANCE PAYMENT AND DEPOSITS REQUIREMENTS BY THIS FACILITY:

If you will be paying for your care from your own funds, no security deposit is required by Saint Joseph Living Center.

Account statements are mailed the fifteenth of each month for the following month's care and are due payable by the first of the month.

If your care will be covered by Medicare, there is no required advance payment or deposit. We will bill you at the end of each month for any co-insurance charges that have become due and any items or services not covered by Medicare.

If you are eligible for Medicaid assistance at this time, there is no required advance payment or deposit and you will not receive a bill from us for the care and services covered by the Medicaid program. For personal items and services not covered under the Medicaid, arrangements for payment through your own personal account may be made.

If you have an application for Medicaid assistance filed with the Department of Income Maintenance, we do not require a deposit.

Should your application be denied, you will be billed for care and services that have been provided and any accrued ancillary charges. If Medicaid assistance is approved retroactively for any care and services for which you have been billed, an appropriate adjustment or refund will be made promptly.

All bills from this facility are due and payable upon receipt. If you have made an advance payment and are entitled to a refund for any reason, refunds will be made in accordance with applicable law.

I acknowledge receipt of this information by signing and returning as part of the application for admission the statement herein enclosed.

My signature below acknowledges that I have received a copy of the Saint Joseph Living Center's statement as well as policies regarding advance payment and security deposits. I acknowledge my understanding of the information.

_____ _____

Name of Applicant Signature of Applicant

_____ _____

Power of Attorney Conservator

_____

Responsible Party

This form must be signed and returned before any applicant may be considered for admission.

PRE-ADMISSION POLICY

Saint Joseph Living Center is a Catholic health care facility which adheres strictly to the moral and ethical teachings of the Church.

Based on the Mission Statement of Saint Joseph Living Center, each resident is surrounded, "with all that is needed to live a quality of life marked by the dignity which is each person's God-given right". It is our commitment to the sacredness of life in all forms that binds our family here in a covenant of love.

In keeping with this belief of the sacredness of life, we adhere to the following: We aim to provide the finest treatment available to residents. When there is no hope for recovery, and death is imminent, excessively burdensome or futile treatment is not indicated. We shall without exception, provide ordinary means including, hygiene and pain relief to the moment of death. Euthanasia in any form can never be condoned.

If at any time a resident or family chooses not to live by our commitment, we will work with that individual in finding a home better suited to their choice.

Saint Joseph Living Center is unable to accommodate those individuals under the age of sixty five (65), or those whom are ventilator dependent.

Should you have any questions, please feel free to contact us.