CANDLEWOOD VALLEY HEALTH & REHABILITATION CENTER

Facility Application

Applicant Information

Name:_____ Phone:_____

Address:_____ Social Security:_____

_____ Birth Place:_____

DOB:_____ Age:_____ Citizen: Yes No Naturalized: Yes No

Sex:_____ Marital Status:_____

Religion:_____ Participating At:_____

Primary Contact:_____ Relationship:_____

Address:_____ Home Phone:_____

_____ Work Phone:_____

Secondary Contact:_____ Relationship:_____

Address:_____ Home Phone:_____

_____ Work Phone:_____

History

Current Diagnosis:_____

Primary Physician:_____ Phone:_____

Significant Past Medical History:_____

_____

_____

Recent Hospitalization at:_____ Admission Date:_____ Discharge Date:_____

Admitting Diagnosis:_____

Attending Hospital Physician:_____ Phone:_____

Applicant Seeking (Check One):

Long Term Placement Short Term Placement

Terminal Placement Other Specialized Medical Treatment Placement

Applicant's Current Living Arrangements:_____

Patient/Family Attitude Towards Placement:_____

Mental Status: Forgetful: Sometimes Always Oriented: Person Place

Confused: Evenings Always New Situations Unresponsive

Hearing Aids: Right Left Does Not Use Vision: Glasses Contacts

Personal Care

Bathing: Self Assist Complete

Dressing: Self Assist Complete Pacemaker

Transfer: Independent Assist x1 Assist x 2 Lift

Ambulation: Bedbound Walker Cane Wheelchair

Services: HHA Yes No # of Times Per Week____ VNA Services Yes No

Bowel: Continent Incontinent Bladder: Continent Incontinent

Catheter Status Indwelling Type:_____ Straight Catheter (Freq.):_____

Skin Integrity: Intact Reddened/Open Areas/Where:_____

Diet:_____ Height:_____ Weight:_____

Allergies:_____

Medications

NAME OF MEDICATION	TAKE AT	FOR

NAME OF TREATMENT	TAKE AT	FOR

Treatments

Does Applicant have a Living Will? Yes No If yes—COPY OF DOCUMENT REQUIRED.

Applicant is Competent / Incompetent , and Makes His/Her Own Decisions.

If Incompetent, Decisions Are Made By:

Conservator Power of Attorney Guardian

Durable Power of Attorney Other (Please Specifiy Title):_____

COPY OF DOCUMENTATION REQUIRED.

Name of Person Making Decision for Applicant:_____ Relationship:_____

Address:_____

Home Phone #:_____ Work Phone#:_____

Financial Information

Social Security#:_____ Medicare #:_____

Title 19#:_____ Pending As Of:_____

DIM Worker & #:_____ Other Medical Insurance & #:_____

COPIES OF THE FRONT AND BACK SIDES OF ALL INSURANCE CARDS (INCLUDING SOCIAL SECURITY) ARE REQUIRED.

Patient's Monthly Income:

Social Security: $_____

VA Benefits: $_____ Benefits #:_____

Pension (CO): $_____ Benefits #:_____

SSI: $_____ Benefits #:_____

CDs: $_____ Bank Acct. #:_____

Annuities: $_____ Source:_____

Dividends: $_____ Source:_____

Other Income: $_____ Source:_____

Person Receiving this Monthly Income:_____

Assets:

BANK	ACCOUNT#	TYPE	AMOUNT

LIFE INSURANCE COMPANY	POLICY#	FACE AMOUNT	BENEFICIARY

Does This Applicant Own Any Property?_____Type:_____

Location:_____

Value:$_____Payable on Mortgage:$_____

Name(s) on Deed:_____

Have There Been Any Dispositions or Transfers of Assets Within the Last 60 months? YES NO

Describe:_____

_____

Veteran: YES NO Service Branch:_____Number:_____

Spouse of Veteran: YES NO

Have Prepaid Funeral Arrangements Been Made? YES NO

Funeral Home:_____Phone:_____

If No Arrangements made, please indicate Funeral Home Preferred:_____

_____

_____

_____

I Certify the Above to be True to the Best of My Knowledge. I Understand the Above Will Be Held in the Strictest Confidence.

_____ _____ _____

Signature Relationship Date

Please share any details about this applicant's daily routine, behavior patterns, or needs that may help us to develop the most comfortable plan of care possible.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

To:_____ Re:_____

THIS AUTHORIZATION (OR PHOTOCOPY HEREOF) WILL AUTHORIZE YOU TO FURNISH TO:

Candlewood Valley Health & Rehabilitation Center
30 Park Lane East
New Milford, CT 06776

ALL INFORMATION YOU MAY HAVE REGARDING MY CONDITION WHILE UNDER YOUR OBSERVATION TREATMENT, EXAMINATION, CONSULTATION, OR CONFINEMENT, INCLUDING THE HISTORY OBTAINED, X-RAY PHYSICAL FINDINGS, DIAGNOSIS AND PROGNOSIS.

Signature	Relationship	Date
Signature	Relationship	Date

ADMISSION CLOTHING NEEDS

Female Suggested Needs	Male Suggested Needs
1 bathrobe	1 bathrobe
3 snap front dusters	8 pair of pajamas
8 nightgown or pajamas	8 pair of socks
8 pair of socks or knee socks	8 pair of underpants
8 pair of underpants	8 T-Shirts
8 T-Shirts, bras or sport bras	8 shirts or sweatshirts
3 sweaters (no wool)	8 pants or sweatpants
8 tops or blouses	3 sweaters (no wool)
8 pants, dresses or skirts	1 pair of shoes
1 pair of shoes	2 pair of slippers (washable)
2 pair of slippers (washable)	1 electric razor

All clothing must be machine washable. We suggest a 50/50 mix, 50% polyester, 50% cotton.

Please be reminded that all clothing and personal items brought into the facility should be left at the reception desk. The Receptionist will notify the clothing department and each item will be marked and recorded in the resident's clothing file before being delivering to the resident's room.

Our offices are available to answer any questions you may have.