GENE & ANJA ROSENBERG
HEBREW HOME
& REHABILITATION CENTER
for health, for life

Jonas R. Steiner, M.S.W., L.C.S.W.
Vice President, Admissions and
Social Work Services

Date: _____

Name: _____

Inquiry List #: _____ as of _____

Dear Family Member:

This letter is in response to your inquiry for admission of the above named to the Hebrew Home & Hospital.

To actively pursue admission to the Hebrew Home & Hospital, the applicant, a family member, or a legally responsible person must fully and accurately complete and return to this office the enclosed *Pre-Admission Application.* Upon receipt of the completed application, the applicant's name will be placed on our Waiting List. Once placed on the Waiting List, we strongly recommend that an appointment be made with the Social Work Services Department to discuss the admission process, as well as the applicant's medical, nursing and emotional needs. At the same time the applicant and/or family member will meet with the Director of Admission to determine the source of payment for care (Medicaid, Medicare, Private Insurance or Self-pay).

If you have any questions, please do not hesitate to call this office at (860) 523-3960.

We look forward to hearing from you again, and working together toward a timely admission to the Hebrew Home & Hospital.

Sincerely,

Jonas R. Steiner, MSW, LCSW
Vice President, Admissions & Social Work Services

Enclosures

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IMPORTANT NOTICE TO ALL APPLICANTS FOR ADMISSION

These documents are provided for informational purposes only. They are not intended to serve as an offer of admission to the Gene and Anja Rosenberg Hebrew Home and Rehabilitation Center. Our clinical staff will be reviewing your application. We will contact you once a final admission decision has been made.

Jonas R. Steiner
Vice President, Admissions & Social Work Services

The Gene and Anja Rosenberg Hebrew Home and Rehabilitation Center, Inc. [OR] Hebrew Health Visiting Nurses, will not exclude from participation in, deny the benefits of, or otherwise discriminate against any eligible person in any of its programs, including employment. All of our programs are open to eligible persons regardless of their race, color, religious creed, sex, age, national origin, ancestry, marital status, sexual orientation, mental retardation or past/present history of mental disorder, learning disability or physical disability. If you have a complaint about unfair treatment, please bring it directly to our President and CEO, Bonnie Gauthier, at (860) 523-3892.

STATE OF CONNECTICUT REGULATION OF CONNECTICUT STATE DEPARTMENT OF SOCIAL SERVICES CONCERNING NURSING HOME DISCRIMINATION AGAINST APPLICANTS FOR ADMISSION

SECTION 17-311-205

You have contacted this nursing home and indicated a desire to be admitted as a patient to this facility. Because of this, you have been sent this pre-assessment application and your name has been placed on our dated list of application inquiries list.

Please find enclosed this facility's written application form. As soon as you substantially complete and return this 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.

Pre-Assessment Application Sheet

Personal Data

Last Name:	First Name:	Middle Name:	Maiden Name:	Application Date:
				/ /

Current address (must include zip code)	Number of Years	Phone Number ( ) Email Address

Is applicant living alone? ☐ Yes ☐ No (If no, with whom do they live?) Name:	Does applicant have home health aide/companion? ☐ Yes ☐ No

Previous address:	Number of Years	Phone Number ( )

Date of Birth:	Place of Birth:	Social Security Number:	Date of Arrival in USA:	Place of Arrival in USA:
/ /		- -	/ /	

Education:	Occupation before retirement:	Date of Retirement:
		/ /

Marital Status: *(Please check one)*

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

Name of Spouse:	Marriage Dates: From: / / To: / /

Are you a veteran? ☐ Yes ☐ No	Are you the spouse of a veteran? ☐ Yes ☐ No	Veteran Number:

Do you have any of the following? *(Please check all that apply.)*

☐ Living Will ☐ Health Care Directive ☐ Power of attorney for healthcare? ☐ Conservator/guardian?

Conservator of Person Name: Street Address: City/State/Zip:	Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( ) Alt. Phone Number: ☐ Bus. ☐ Home ☐ Cell ( ) Email Address:
Conservator of Estate Name: Street Address: City/State/Zip:	Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( ) Alt. Phone Number: ☐ Bus. ☐ Home ☐ Cell ( ) Email Address:
Power of Attorney Name: Street Address: City/State/Zip:	Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( ) Alt. Phone Number: ☐ Bus. ☐ Home ☐ Cell ( ) Email Address:
Applicant's Physician Name: Street Address: City/State/Zip:	Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( ) Alt. Phone Number: ☐ Bus. ☐ Home ☐ Cell ( ) Email Address:

Interested Relatives and/or Parties

Name, address, zip code, relationship to applicant	Phone / Email
Name, address, zip code, relationship to applicant	Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )
	Alt. Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )
	Email Address:
Name, address, zip code, relationship to applicant	Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )
	Alt. Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )
	Email Address:
Name, address, zip code, relationship to applicant	Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )
	Alt. Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )
	Email Address:
Name, address, zip code, relationship to applicant	Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )
	Alt. Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )
	Email Address:

Insurance Data

Medicare Number	Medicaid Number	Pending Medicaid Approval?	Application Date:	Applying Agency	Name of State Worker
		☐ Yes ☐ No	/ /		

Name of Insurance Carrier:	Insurance Policy Number:
Name of Insurance Carrier:	Insurance Policy Number:

Medical Data/Nursing History

Applicant's Living Arrangement: *(Please check all that apply)*

☐ Resides in a Nursing Home

Name and Address of Facility:

Functional Needs

The Applicant requires assistance/is independent in the following areas: *(Please check all that apply)*

Bathing:	☐ Independent	☐ Needs Assistance	Dressing:	☐ Independent	☐ Needs Assistance
Grooming:	☐ Independent	☐ Needs Assistance	Toileting:	☐ Independent	☐ Needs Assistance
Cooking:	☐ Independent	☐ Needs Assistance	Housekeeping:	☐ Independent	☐ Needs Assistance
Shopping:	☐ Independent	☐ Needs Assistance	Budgeting:	☐ Independent	☐ Needs Assistance
Banking:	☐ Independent	☐ Needs Assistance	Walking:	☐ Independent	☐ Needs Assistance
Transferring:	☐ Independent	☐ Needs Assistance	Eating:	☐ Independent	☐ Needs Assistance
Continent of Bladder:	☐ Yes	☐ No	Continent of Bowel:	☐ Yes	☐ No

Hospitalizations

List Hospital Name(s), Date(s) of Admission, Reason(s) for Hospitalization and Address if out of area:

Medical Data/Nursing History (*continued)*

If applicant has been seen by a psychiatrist, please list name, address, date and reason for consultation.

If applicant has been seen by a neurologist, please list name, address, date and reason for consultation.

If applicant has been treated for drug/alcohol abuse, please list name, address, and dates.

Religious Data

Religion	Name and Address of Synagogue/Church Affiliation

Name and Address of Preferred Funeral Home	Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )
Name and Address of Cemetery	Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )

Hebrew Names (*if applicable*)

Client: Client's Father: Client's Mother:

Reason for Application

Please supply all appropriate information for the admission interview. This information is needed before application can be processed for admission into the Gene and Anja Rosenberg Hebrew Home and Rehabilitation Center. Please see list on last page.

ADMISSION FINANCIAL RECORD

Applicant Name: Street Address: City/State/Zip:	Social Security Number: - - Medicaid Number: Primary Phone Number: ☐ Bus. ☐ Home ☐ Cell ( )

Financial Record	**Amounts**
Current Monthly Income:	
Social Security	$
Pension	$
Trust Fund – Principal or Monthly Income	$
Other:	$
Capital Assets ☐ Individually Held ☐ Jointly Held	$
Cash on Hand	$

Other Assets:

Bank Name	Bank Address	Account Number	Account Balance
			$
			$
			$

Stocks and Bonds	Value
	$
	$
	$

Real Estate (Owned and Mortgages)

	$
Total	$

Insurance Policies

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

Assets Disposed of in the Last Three Years (Include type of asset)	Value
	$
	$
	$
Total	$

Debts and Obligations	Amounts
	$
	$
Total	$

Power of Attorney: Name: Street Address: City/State/Zip:	Conservator/Power of Attorney/Responsible Party: Name: Street Address: City/State/Zip:

ALL FIGURES MUST BE SUPPORTED WITH COPIES OF BANK STATEMENTS, PASSBOOKS AND FINANCIAL STATEMENTS.

The Gene and Anja Rosenberg Hebrew Home and Rehabilitation Center **does not request assets be turned over as a contingency for admission.** ***Photocopies of the following are required***: Power of Attorney; Living Will; Durable Power of Attorney for Health Care; Health Care Agent; Conservatorship; Medicare Card; Social Security Card; All Insurance Cards

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Please supply all appropriate information requested below for the admissions process. This information is necessary for admission to the Gene and Anja Rosenberg Hebrew Home and Rehabilitation Center. If you have questions, please contact the Department of Admissions and Social Work Services at 860-523-3960.

THIS IS ONLY A CHECKLIST - DID YOU PROVIDE THE FOLLOWING ON THIS APPLICATION?

- ☐ Current Physician Information – Full name, address, zip code and phone number.
- ☐ Financially Responsible Person – Full name, address, zip code, phone numbers and email address.
- ☐ Power of Attorney (copy)
- ☐ Conservatorship (copy)
- ☐ Emergency Contact Person – Full name, address, zip code, phone numbers and email address.
- ☐ Medicare Card (copy)
- ☐ Social Security Card (copy)
- ☐ Insurance Cards(s) (copy)
- ☐ Hospitalizations – Hospital name and address, dates of admission/exact year, and physician.
- ☐ *Financial Status – Completed Admission Financial Record form.
- ☐ Health Care Directive (copy)
- ☐ Living Will (copy)
- ☐ Durable Power of Attorney for Health Care
- ☐ Health Care Agent
- ☐ Burial Arrangements – Cemetery Name, Mortuary/Funeral Home Name
- ☐ Religious Affiliation
- ☐ Synagogue or Church Name
- ☐ Hebrew Name(s) – Applicant's Name, Applicant's Parents Names
- ☐ Other Interested Individuals – Full name, address, zip code, phone numbers and email address.
- ☐ Other Relevant Information (specify)

*The State of Connecticut requires financial history from February, 2006 to present, for persons applying for Medicaid. See enclosed information sheet.