

The Hannah Gray Home
"A 19th Century Dream, A 21st Century Mission"

Admission Application

Thank you for contacting The Hannah Gray Home regarding your desire to be admitted as a resident to this facility. You have been issued a receipt indicating the date and time of your initial request, and your name has been placed on our **INQUIRY LIST**.

Receipt # _____

Please answer all of the questions contained in this application. If an item is not applicable, please write "Not Applicable" or "N/A" in the space provided for an answer. If you need more room to answer any of these questions, you may insert a personal note to this form. After you have substantially completed and returned this form to The Hannah Gray Home, your name will be placed on our waiting list for admission to the facility.

The information presented in this application is correct to the best of my knowledge. I have no objection to inquiries for the purpose of verification. I understand that misinformation or failure to report changes in information shall constitute grounds for rejection of my application.

Signature of Applicant: _____

Signature of Responsible Party: _____

Relationship to Applicant: _____

Please Return to: The Hannah Gray Home, Inc. Tel: (203) 907-4052
 235 Dixwell Avenue Fax: (203) 907-0446
 New Haven, CT 06511 www.hannahgrayhome.com

FOR ADMISSIONS OFFICE USE ONLY			
Applicant Name:	_____		
Placement Date:	_____	Time:	_____
Placement Date:	_____	Time:	_____

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Legal Name of applicant, as it appears on Medicare or Medicaid card

Last _____ First _____

*MI _____

Home Address _____ City _____ County _____

State _____ Zip Code _____ Telephone _____

APPLICANT HISTORY

Has the Applicant previously been in a Nursing Facility? Yes No

If yes, please list facility name and dates of stay

Social Security Number _____ Date of Birth _____ Sex _____

Primary Language _____ Secondary Language _____

Marital Status _____ Spouse Name _____ Birthplace _____

Education _____ Occupation _____

Citizenship _____ Maiden _____ Father _____ Mother _____

Religion _____ Funeral Home _____

RESPONSIBLE PERSON(S)

Does anyone hold: Power of Attorney Conservator of Person Conservator of Estate

If yes, please fill out the following and provide copies with your application:

Name _____ Relationship _____

Home Address _____ City _____ County _____

State _____ Zip Code _____ Home Phone _____ Work Phone _____

Name _____ Relationship _____

Home Address _____ City _____ County _____

State _____ Zip Code _____ Home Phone _____ Work Phone _____

Other Contacts:

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Other _____

Name _____ Relationship _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Other _____

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INSURANCE COVERAGE

Are you a Veteran? Yes No OR Spouse of a Veteran? Yes No

Medicare Number _____

Medicaid Number _____ Effective Date _____ County _____

Pending Case Worker _____ *Date

Applied _____

Other Medical Insurance _____ Policy Number _____

Prescription Coverage _____ Policy
Number _____

Medicare Part D Plan ID _____ Group
Number _____

Long Term Care
Insurance _____

(You are responsible to contact upon admission)

CONFIDENTIAL FINANCIAL INFORMATION

Monthly Income

	<u>Applicant</u>	<u>Spouse</u>
Salary	\$ _____	\$ _____
Social Security	\$ _____	\$ _____
Retirement Pension	\$ _____	\$ _____
Veteran Pension	\$ _____	\$ _____
(IRA, Trust, Etc...)	\$ _____	\$ _____
401K (Other)	\$ _____	\$ _____
Other Income (Specify)	\$ _____	\$ _____
Total Monthly Income	\$ _____	\$ _____

<u>Assets</u>	<u>Check if Applicable</u>	<u>Approximate Value</u>	<u>Name(s) Owner</u>
Owns Real Estate	_____	\$ _____	
Life Insurance (cash value)	_____	\$ _____	
Trust Account/Type	_____	\$ _____	
Stocks/Bonds	_____	\$ _____	
Annuities	_____	\$ _____	

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Pre-paid Funeral Home _____ \$ _____

(Please list)

Bank Accounts (Checking, Savings, Other)

(Please list)

<u>Names on Account</u>	<u>Type</u>	<u>Approximate Value</u>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
	Total Assets	\$ _____

Have any assets been transferred from the Resident to others in the last 60 months?

Yes No

Are you currently working with an attorney? Yes No

If yes, name of firm _____ how long have you been working with this Attorney/Firm _____ and reason for retaining:

Nursing Home Placement

Real Estate Trust Fund/Account Personal

Other _____

CONFIDENTIAL HEALTH HISTORY

Please list dates and nature of major illnesses, hospital stays, operations or therapy treatments:

Date:	Description
_____	_____
_____	_____
_____	_____

What medications do you presently use? Please list both prescription and non-prescription meds.

Prescription	Non Prescription
_____	_____
_____	_____

