Avery Heights
A Village of CHI

FOR OFFICE USE ONLY

Applicant:____
Last **First** **Middle**

Placement Date:_________________

Level of Care:___________________

Admission Application

Thank you for contacting us and indicating your desire to become a resident of Avery Heights. Because of this, 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.

As soon as you substantially complete, sign and return the Admissions Application to the Admissions Coordinator at Avery Heights, your name will be placed on our waiting list.

Please answer all the questions. If an item is not applicable please so state. If you need more room to answer any of these questions, please use the back of this form.

Avery Heights is a smoke-free facility.

Avery Heights is owned and operated by Church Homes, Inc., a not-for-profit, nonsectarian corporation. Avery Heights provides a wide range of residential, health and social services, as well as assistance in living services, to individuals regardless of race, color, religion, age, sex, marital status, physical handicap, national origin, and diagnosis or gender preference.

All information is confidential and will not be used without prior authorization per HIPAA

Please return to:

Admissions Coordinator, Avery Heights,
705 New Britain Avenue, Hartford, CT 06106
Telephone: (860) 527-9126, ext. 433
FAX: (860) 728-0225

PERSONAL INFORMATION

Legal Name: ____

Street Address: ____

City, State, Zip: ____

Phone Number: ____

Birthdate: ____

Marital Status: ____

Veteran Number: ____

EMERGENCY CONTACTS

Name:_______________________________ **Relationship:**_______________________
Address:____
____
E:mail:____
Home Phone:_________________________ **Business Phone:**_____________________

Name:_______________________________ **Relationship:**_______________________
Address:____
____
E:mail:____
Home Phone:_________________________ **Business Phone:**_____________________

Name:_______________________________ **Relationship:**_______________________
Address:____
____
E:mail:____
Home Phone:_________________________ **Business Phone:**_____________________

From time to time, Avery Heights may send out a query regarding the applicant's desire to keep his name on the waiting list. According to regulation, we must send this notice to the applicant and one other designated party. Other than the applicant, to who should queries regarding waiting list placement be sent?

Name:_______________________________ **Relationship:**_______________________
Address:____

MEDICAL INFORMATION

Physician Name: ____________________________ Phone: _______________
Address: _____________________________________ Fax: _________________
____
Home Care Agency:__________________________ Phone:_________________
Psychiatric Care Provider: ______________________ Phone: ________________
Hospital Preference: ____
Dates of stay at other healthcare facilities: ________________________________

It is our policy to respect and recognize the rights of our patients to self-determination in medical decisions.

Do you have the following:

- ☐ Living Will
- ☐ Advance Directive regarding health care
- ☐ Eye, organ or body donor arrangements
- ☐ None of the above

Please provide a copy of each document.

FINANCIAL INFORMATION

Church Homes, Inc. asks that you complete the following financial section of the application. Should you at any time have questions or concerns please contact the Admissions Coordinator. All Church Homes Villages participate in the Medicare and Medicaid programs.

Name:____________________________________ **Date:**___________________
Social Security Number:____
____

Name of person to whom bills should be sent:_____________________________
Address:____
Phone Number: ______________________________

Name of your attorney:____
Address:____
Phone Number: ______________________________

Name of person who holds any of the following: __________________________

________ Power of Attorney (financial)
________ Health Care Proxy
________ Power of Attorney for health and finances
________ Legal Guardian/Representative
________ Conservator of Person
________ Conservator of Estate
________ Springing Power of Attorney
________ Future Designation of Conservator

INSURANCE

Traditional Medicare:
Medicare Part A (Hospital Insurance)________________Effective Date:________
Medicare Part B (Medical Insurance)________________ Effective Date:________

Medigap/Medicare Supplemental Policy:
Name of Company ____________________________ Policy Number __________

Medicare HMO:
Name of Company ______________________________________ Policy Number_______________

Additional Medical Insurance/ Long Term Care Insurance:
Name of Company ______________________________________ Policy Number_______________

Life Insurance:
Name of Company _____________________ Policy Number___________ Cash Value___________

Name of Company _____________________ Policy Number___________ Cash Value___________

Have you applied for Medicaid (Title 19)? ☐ Yes ☐ No
Is your application ☐ Approved ☐ Denied ☐ Pending

Medicaid Claim Number:________________________________ Effective Date: ______________

Name of Caseworker:___________________________________ Phone Number: ______________

Please provide copies of your insurance cards.

MONTHLY INCOME

Social Security	$	**Railroad/Teacher's Retirement**	$
Pension/Retirement	$	**Annuity**	$
VA Benefits	$	**Interest Income**	$
		Other	$
		Total Monthly Income	$

BANK ACCOUNTS

Checking:	Bank		Names on Account		Balance	
Savings:	Bank		Names on Account		Balance	
Savings:	Bank		Names on Account		Balance	
Savings:	Bank		Names on Account		Balance	
CD:	Bank		Names on Account		Balance	
CD:	Bank		Names on Account		Balance	
CD:	Bank		Names on Account		Balance	
Other:	Bank		Names on Account		Balance	

STOCKS/BONDS

Do you own any stocks? ☐ **Yes** ☐ **No**

Company Name _________________ Value____________________
Company Name _________________ Value____________________

Do you own any bonds? ☐ **Yes** ☐ **No**

Company Name _________________ Value____________________
Company Name _________________ Value____________________

REAL ESTATE/PROPERTY

Do you own any real estate? ☐ Yes ☐ No
Please describe, including location and approximate value ____________________________
____
____

Does your spouse currently live in the house? ☐ Yes ☐ No

Do you have "life use" (any ownership interest) of any real estate, in full or in part for your lifetime, or the right to occupy property for your lifetime? ☐ Yes ☐ No

Do you own an automobile? ☐ Yes ☐ No Year________ Model_____________

Have you transferred or given away any assets of any kind (cash, real estate, securities, etc.) or transferred assets of any kind for less than fair market value within the last 60 months?
☐ Yes ☐ No

If yes, please include the asset transferred, value, name and address of person to whom the asset was transferred. ____
____

Have you gifted any money over $100.00 in the last 60 months? (children; grandchildren; churches)
☐ Yes ☐ No

TRUSTS

Do you receive income from or have interest in any trust? ☐ Yes ☐ No

Please describe and attach a copy of trust document.___________________________________
____

Name of trust officer______________________________ Phone Number_________________
Address____
____

Within 5 years prior to the date of this application, have you created any trust or placed funds or assets in a trust? ☐ Yes ☐ No

Please describe and attach a copy of trust document. __________________________________
Name of trust officer ____________________________ Phone Number__________________
Address____
____

The Department of Social Services states that an applicant may be ineligible if, within 60 months prior to the date of application for Medicaid (Title 19) Assistance, he/she made an assignment, transfer or other disposition of assets or other resources for less than fair market value for the purpose of qualifying for Medicaid Assistance.

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 the rejection of my application.

Signature of Applicant____

Signature of Responsible Party_____________________________________

Print Name ____

Relationship to Applicant____

Date_________________________