MCNR
Mansfield Center for
Nursing and Rehabilitation

Application for Admission

Thank you for inquiring about Mansfield Center for Nursing & Rehabilitation for possible admission. 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 issued a receipt indicating the date and time of your initial request and your name has been placed on our inquiry list.

Receipt # _____

As soon as you substantially complete and return the Applicant Information Form and the Financial Disclosure Form to Mansfield Center for Nursing & Rehabilitation your name will be placed on our waiting list for admission to the facility. Your name will be placed on our waiting list only after you substantially complete and return both written application forms to us.

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

Please return to:

Mansfield Center for Nursing & Rehabilitation
100 Warren Circle
Storrs, Connecticut 06268
(860) 487-2300

MCNR
Mansfield Center for Nursing and Rehabilitation

APPLICATION FOR ADMISSION

1. *PERSONAL INFORMATION*

Name: _____ Maiden Name: _____ Telephone: _____

Address: _____ City: _____ State_____ Zip _____

Place of Birth: _____ Date of Birth: _____ Age: _____ Marital Status: _____

2. *GENERAL INFORMATION*

Religious Affiliation: _____ Name of Church _____

Applicant's former occupation: _____ Education: _____

Date of Retirement: _____ With whom is the applicant living now? _____

Veteran / Spouse Veteran: _____ Dates of Service: _____

Primary Care Physician: _____ Telephone: _____

Applicant is presently at: Home _____ Hospital _____ Nursing Facility _____ other _____

Name of any prior Nursing Facility(s): _____ Date(s): _____

3. *EMERGENCY CONTACTS*

NAME		RELATIONSHIP	POA YES [ ] NO [ ]	CONSERVATOR YES [ ] NO [ ]
ADDRESS		TOWN		ZIP
HOME TELEPHONE	WORK TELEPHONE		CELL PHONE	

NAME		RELATIONSHIP	POA YES [ ] NO [ ]	CONSERVATOR YES [ ] NO [ ]
ADDRESS		TOWN		ZIP
HOME TELEPHONE	WORK TELEPHONE		CELL PHONE	

4. *HEALTH INFORMATION*

Please list/describe current medical condition: _____

_____

_____

Height: _____ Weight: _____

Was the applicant every in need of psychiatric treatment? Yes _____ No _____

Please Explain: _____

_____

Does the applicant require any special equipment? _____

Current Medications: _____

5. *BILLING INFORMATION*

Social Security Number: _____-_____-_____ Medicare Number: _____ Part A: _____ Part B: _____

Medicaid Number: _____ Medicaid Application Pending: Yes _____ No _____

Medicare Part D or Pharmacy Drug Plan: _____

Insurance Company: _____ Policy Number: _____

Long-term Care Insurance Policy: Yes _____ No _____

Insurance Company: _____

Policy Number: _____ Telephone: _____

Do you receive Medicare from a Disability? Yes _____ No _____

Have you received Physical Therapy, Occupational Therapy or Speech Therapy Services covered by Medicare Part B in the past year? Yes _____ No _____ If so, which facility: _____

Applicant's Monthly Income

Social Security $_____ Pension/ Retirement $_____

Annuities $ _____ Mutual Funds $ _____

Railroad/ Teachers Retirement $ _____ VA Benefits $_____

Miscellaneous $ _____ Total Monthly Income $_____

Applicant's Bank Accounts

Bank	Acct #	Type	Name(s) on Account	Balance

Stocks/Bonds

Do you own any stocks: Yes_____ No_____?

Company Name: _____ Value _____

_____ Value _____

Real Estate/Property

Do you own any Real Estate? Yes____ No ____

Please describe, including location and value: _____

_____

Has the applicant sold or given away any real estate in the past 5 years? Yes _____ No _____

Please Explain: _____

Is the applicant spouse living in the house now? Yes _____ No _____

With whom is the applicant living now? _____

Does the applicant own an automobile? Yes _____ No _____

Have you made Funeral arrangements? Yes_____ No _____

Name of Funeral Home? _____

Life Insurance Company	Policy #	Type of Policy	Face Value

Trust

Does the applicant receive income from or have any interest in any trust? Yes _____ No_____

Please Describe: _____

Name of Trust Officer: _____

Address: _____

Phone: ( ) _____

Do you anticipate applying for Medicaid? Yes_____ No _____

If yes, when do you anticipate you will apply? _____

Gifts, Transfers of Assets, and Transfers to an Irrevocable Trust within last 60 months? Yes____ No ____

Type of Transfer	Value	To Whom	Address	Relationship	Date of Transfer

Who is your attorney? _____

Address: _____

Phone: _____

Person responsible for payment of account:

Name: _____

Relationship: _____ Telephone: Home _____ Work _____

Address: _____ Town: _____ State: _____ Zip: _____

Person to receive inquiries about waiting list placement:

Name: _____ Telephone: _____

Address: _____ Town: _____State: _____ Zip: _____

Does anyone hold?

POA _____ Conservator of Person _____ Conservator of Estate _____ Guardianship_____

Name & Address: _____

_____

Please Provide the Following Information with Application

- Photocopy of Medicare/ Medicaid card
- Photocopy of Insurance card(s)
- Photocopy of Living Will, if applicable
- Photocopy of Conservator Appointment, if applicable

The information presented in this financial disclosure is correct to the best of my knowledge. I have no objection to inquiries for the purpose of verifying it. I understand that misinformation or failure to report changes shall constitute grounds for rejections of their application. My signature herein indicates that I understand that MCNR is relying on the information and representation I have made herein in deciding whether to admit applicant.

Signed: _____ Date: _____

Print Name: _____ Date: _____

Relationship to Applicant: _____ Date: _____