



Hughes Health & Rehabilitation

Caring for loved ones. Family style

YOU HAVE CONTACTED THIS NURSING HOME AND INDICATED A DESIRE TO BE ADMITTED AS A RESIDENT TO THIS FACILITY. BECAUSE OF THIS, YOU HAVE ALREADY BEEN ISSUED A RECEIPT INDICATING THE DATE AND TIME OF YOUR INITIAL REQUEST AND YOUR NAME HAS BEEN PLACED ON OUR DATED LIST OF APPLICATIONS OR INQUIRY LIST.

PLEASE FIND ENCLOSED THIS FACILITY'S WRITTEN APPLICATION FORM. AS SOON AS YOU SUBSTANTIALLY COMPLETE AND RETURN THE FORM TO THE FACILITY, 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 THIS WRITTEN APPLICATION FORM TO US.

Name and address of present physician: _____

Will this physician continue your care if you are _____ Yes _____ No

If not, who will? Physician's name and address _____

Do you have any specialist physicians? If so, who? _____

Hospital preference: _____ Ambulance preference: _____

Please give dates and nature of any major illnesses or operations you have experienced:

Have you been seen within the last two (2) years by an ophthalmologist or an optometrist for vision testing? _____

If yes, please state who and when: _____

Have you ever lived in a place like Hughes Health and Rehabilitation before? _____ Yes _____ No

If yes, please state where and when: _____ from _____ to _____

Have you ever been treated for any nervous or emotional disorder? _____

If yes, please state where and when: _____ from _____ to _____

Have you ever been treated for: Alcohol abuse _____ Drug abuse _____ Other _____

If yes, please state where and when: _____ from _____ to _____

Can you completely care for yourself without assistance? _____ Yes _____ No

If not, in what way do you need assistance?

Medicaid number: _____ Worker's name: _____

Medicare number: _____ Med A _____ Med B _____

Med D company: _____ Med D ID number: _____

Blue Cross: _____ Other insurance: _____
Name Number

Other insurance: _____
Name Number

Do you own a Connecticut Partnership for Long-Term Care approved insurance policy? _____

How were you referred to Hughes Health and Rehabilitation _____

Name of person responsible for the account: _____

Mail bills to: _____

Phone: _____ (H): _____ (W): _____ (Cell): _____

Other remarks:

Hughes Health and Rehabilitation, Inc.

Confidential Financial Statement

Resident's Name _____

HUGHES HEALTH AND REHABILITATION, INC. needs a complete accounting of the following information in order to ensure that timely decisions are made concerning payment for your care.

FINANCIAL

Social Security #: _____ Medicare #: _____ Medicaid (TXIX) #: _____

Does applicant have an application pending for State Medicaid (TXIX)? Yes: _____ No: _____

If so, who is the Caseworker? _____ What DSS office? _____

Other Medical/Hospital

Name of Company	Subscriber/Group #	Type of Insurance
_____	_____	_____

Life Insurance List all life insurance policies face amounts and cash surrender value amounts.

Name of Policy	Face Amount	Cash Surrender Value
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

Funeral Account Has the applicant established an irrevocable burial account? Yes: _____ No: _____

If so, with what Funeral Home? _____

Amount currently in Funeral Account \$ _____

Income

Social Security \$ _____/Mo. Check is being mailed or direct deposit to: _____

Pensions \$ _____/Mo. Check is being mailed or direct deposit to: _____

Source _____

\$ _____/Mo. Check is being mailed or direct deposit to: _____

Source _____

VA Benefits \$ _____/Mo. Check is being mailed or direct deposit to: _____

Annuities \$ _____/Mo. Check is being mailed or direct deposit to: _____

Source _____

Interest \$ _____/Mo. Check is being mailed or direct deposit to: _____

Source _____

Dividends \$ _____/Mo. Check is being mailed or direct deposit to: _____

Source _____

Other Income \$ _____/Mo. Check is being mailed or direct deposit to: _____

Source _____

Trusts

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

If yes, please describe and provide a copy of the trust instrument.

Assets

If any asset is jointly held, please give name of joint owner. _____

Real Estate

Does applicant own any real estate? Yes: _____ No: _____

Address of Property	Description of Property	Approximate Value	Name(s) on Deed
_____	_____	\$ _____	_____
_____	_____	\$ _____	_____

Are there any liens or mortgages against the property? Yes: _____ No: _____

If so, please list which property, amount of Lien and the name of Lien-holder. _____

Was this real estate your home prior to entering to nursing home? Yes: _____ No: _____

Is your spouse now living in the _____ Yes: _____ No: _____

Do you have a "life use" of any real estate? Yes: _____ No: _____

If so, what address and who owns the property _____

Cash Assets

Please list all assets including but not limited to: Savings and Checking Accounts, Stocks, Bonds,

Name of	Account #	Present Balance
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Transfer of Assets

Within 60 months prior to the date of this application, have you given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind (cash, securities, real estate, etc.)? Yes: _____ No: _____

If yes, please describe fully all such gifts or transfers of \$1,000 or more, including the asset transferred, names, addresses and relationship to you of the person to whom the gift or transfer was made, and the value of the gift or transfer. _____

Within 60 months prior to the date of this application, have you created any trusts or placed funds or any other assets in a trust that already existed? Yes: _____ No: _____

If yes, please describe and provide a copy of the trust instrument.

I hereby certify that this is a true and complete statement of the applicant's current income and assets and any gifts or transfers of \$1,000 or more and any trusts created or transfers of assets to any trust that they have made within the 60 months (5 years) prior to the date of this application.

Resident's Signature Date

Responsible Party's Signature Date

HUGHES HEALTH and REHABILITATION, INC.

**INFORMATION TO ALL APPLICANTS REGARDING
TITLE XVIII AND TITLE XIX FINANCIAL BENEFITS**

After completing our financial statement, many of our applicants become concerned that their assets will not be sufficient to meet their medical expenses in future years. At Hughes Health and Rehabilitation, Inc. we make every effort to keep costs of our home to a minimum. At the same time, we ask you to do the most you can to protect your present resources and discuss with your families the extent of assistance they can provide.

If your resources should be depleted in the future, the resident is still responsible for the costs of his or her care, and will need to seek any available financial assistance. Hughes Health and Rehabilitation, Inc. has a provider agreement with the state to provide services to Medicaid recipients pursuant to Title XIX of the Social Security Act and participates in Medicare pursuant to Title XVIII of the Social Security Act. You should not assume that Medicare or Medicaid will automatically pay for the cost of care; you will have to meet eligibility requirements for Medicare or Medicaid.

In such event, you should be aware of a common problem that may cause rejection or delay in obtaining assistance from the State. That problem is a transfer of assets made by our residents within three years of their need to apply for benefits.

Before a person can obtain financial benefits, a study of their situation is conducted, and according to the State's procedures:

"The determination of eligibility will include an examination of the past and present property holdings of the applicant to determine that, within the thirty-six months immediately prior to the date of application for Public Assistance, resources have not been assigned, transferred, or otherwise disposed of for less than fair market value for the purposes of establishing eligibility for benefits." (Connecticut State Department of Income Maintenance, Public Assistance Manual, Vol. 1, Chapter III, sect. 326, Para. A.)

These transfers can take many forms, including but not limited to:

- "(1) Deeding real estate to relatives, friends, or institutions;
- (2) Sale or other disposition of 'life use' of real estate;
- (3) Transfer of bank account or securities to another person;
- (4) Assignment of life insurance;
- (5) Establishing a trust fund." (Chapter III, sect. 329, para. D)

If you have any questions about whether you have made such a transfer, or whether you would like to make a transfer, or what you should do if you have made a transfer, please contact your attorney immediately. Please, tell us about it so that we can anticipate any problems that may arise.

I have read this statement and understand its contents.

Signed: _____ Date _____
Resident / Conservator of Person / Attorney-in-Fact / Responsible Party

HUGHES HEALTH & REHABILITATION, INC.

Required Admission Information

Please supply the following information either prior to or on the day of admission:

1. Power of Attorney (copy)
2. Conservator (copy)
3. Emergency contact person - name, address, telephone number(s)
4. Medicare Card or copy (both sides)
5. Social Security Card or copy (both sides)
6. Any other current Insurance Cards or copies (both sides)
7. Health care Directives or copies:
 - Living Will
 - Health Care Agent
 - Durable Power of Attorney
8. Military Service Information. It is important that information on the application regarding Military Service is answered. (It may mean additional benefits for the applicant)