Noble HORIZONS

Admission Application

Please return to:
Noble Horizons 17 Cobble Road Salisbury, CT 06068
860-435-9851, ext. 141 Fax: 860-435-2323
www.noblehorizons.org

FOR ADMISSIONS OFFICE USE ONLY

Applicant _____
last first middle

Date Received _____ Time _____

Thank you letting us know of your interest in joining the Noble Horizons community. Once you complete and return this form, your name will be placed on our waiting list for admission.

Please answer all the questions and attach an additional sheet if necessary. If a question is not applicable, please write N/A in that space.

Receipt # _____

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 _____

Date _____

Signature _____

Relationship to Applicant _____

Please return to: Noble Horizons
17 Cobble Road
Salisbury, CT 06068
Tel: (860) 435-9851 x 141 Fax: (860) 435-2323
www.noblehorizons.org

Personal Information

1. Name Last _____ First _____ Middle _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: Home ( ) _____ Cell ( ) _____
Business ( ) _____ Fax ( ) _____ Email _____

2. Birthdate _____ Birthplace _____
Social Security # _____

3. Are you ❑ married ❑ single ❑ widowed ❑ divorced
Spouse's Name Last _____ First _____ Middle _____
Spouse's Address _____ State ____ Zip _____

Family Information

4. Your Father's Full Name _____ Your Mother's Full Name _____

5. Your Children: (list 5A-5C) _____ Your Mother's Maiden Name _____

5A Name Last _____ First _____ Middle _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: Home ( ) _____ Cell ( ) _____
Business ( ) _____ Fax ( ) _____ Email _____

5B Name Last _____ First _____ Middle _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: Home ( ) _____ Cell ( ) _____
Business ( ) _____ Fax ( ) _____ Email _____

5C Name Last _____ First _____ Middle _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: Home ( ) _____ Cell ( ) _____
Business ( ) _____ Fax ( ) _____ Email _____

Please list additional children on page 6. (list 5D-5F)

In Case of Emergency, Notify:

6. Name _____ Relationship _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: Home ( ) _____ Cell ( ) _____
Business ( ) _____ Fax ( ) _____ Email _____

7. Nearest close relative or trusted friend (other than those listed above): Relationship _____
Name Last _____ First _____ Middle _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: Home ( ) _____ Cell ( ) _____
Business ( ) _____ Fax ( ) _____ Email _____

Information About You

8. With whom are you living now and for how long? Please include their relationship to you _____

_____

9. What is your education? _____

_____

10. What is (was) your lifetime occupation? _____
What is the name of your last employer? _____

11. Are you now fully retired? ❑ Yes ❑ No Semi-retired? ❑ Yes ❑ No

12. Are you a veteran? ❑ Yes ❑ No Spouse of a veteran? ❑ Yes ❑ No
Branch of Service _____ Rank _____

13. What are your present interests, activities and volunteer involvements? _____

_____

14. Are you a member of a church, synagogue, or other religious body? ❑ Yes ❑ No ❑ Active ❑ Inactive
Religion _____ Local Place of Worship _____

15. Please designate a funeral home (required):
Funeral Home _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: ( ) _____ Cell ( ) _____
Fax ( ) _____ Email _____

16. Who is your attorney?
Name Last _____ First _____ Middle _____
Mailing Address City _____ State ____ Zip _____
Telephone: ( ) _____ Cell ( ) _____
Fax ( ) _____ Email _____

17. Does anyone hold: ❑ Power of Attorney ❑ Conservator of the Person ❑ Conservator of Estate
If yes, please fill out the following and provide copies with your application:
Name Last _____ First _____ Middle _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: Home ( ) _____ Cell ( ) _____
Business ( ) _____ Fax ( ) _____ Email _____
Name Last _____ First _____ Middle _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: Home ( ) _____ Cell ( ) _____
Business ( ) _____ Fax ( ) _____ Email _____

18. Do you have any of the following advance directives regarding health care? ❑ Health Care Agent
❑ Eye, Organ or Body Donations ❑ Durable Power of Attorney for Health Care ❑ Living Will
Please enclose a copy of any advance directives you do have with your application.

19. Would you like information on the subject of advance directives? ❑ Yes ❑ No

Confidential Financial Information

About the Confidential Financial Statement
Noble Horizons asks that you complete the following financial section of this application. Should you at any time have questions and concerns, please contact the Director of Admissions. This statement must be updated at the time of Admission. Noble Horizons participates in the Medicare and Medicaid programs.

20. Assets:

Checking	$	**Monthly Income:**	
Real Estate	$	Social Security	$
Savings	$	Pension & Retirement	$
Investments	$	Investments	$
Stocks & Bonds	$	Dividends	$
Annuities	$	Other	$
Total Assets	**$**	**Total Monthly Income**	**$**

21. Do you receive income or have any interest in a trust? ❑ Yes ❑ No If yes, please describe and provide a copy of the trust instrument. _____

22. Do you have any real estate holdings? ❑ Yes ❑ No If yes, please describe and give the approximate value of your home. _____

23. Do you have Life Use of any real estate, any ownership in full or in part for your lifetime, or the right to occupy property for your lifetime? ❑ Yes ❑ No If yes, please describe. _____

24. If any assets are jointly held, please give name of joint owner and their relationship to you. _____

25. Has there been any disposition or transfer of assets within the past 60 months? ❑ Yes ❑ No If yes, please explain. _____

26. Are there any obligations against any of these assets? ❑ Yes ❑ No If yes, please explain. _____

27. Are any of these assets held in trust? ❑ Yes ❑ No If yes, please explain. _____

28. Trust Officer's Name _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: ( ) _____ Fax ( ) _____ Email _____

29. Who will pay your bill? ❑ Myself ❑ Other If other, please provide the information below:
Name Last _____ First _____ Middle _____
Mailing Address _____ City _____ State ____ Zip _____
Telephone: Home ( ) _____ Cell ( ) _____
Business ( ) _____ Fax ( ) _____ Email _____

Confidential Health History

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

Date _____ Description _____

_____ _____

_____ _____

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

Prescription _____ Non-Prescription _____

_____ _____

32. Have you ever been treated for mental illness, a nervous condition or psychosocial disorder?

❑ Yes ❑ No If yes, where and when? _____

33. Can you care for yourself completely and without assistance? ❑ Yes ❑ No If not, who will:

Name Last _____ First _____ Middle _____

Mailing Address _____ City _____ State ____ Zip _____

Telephone: Home ( ) _____ Cell ( ) _____

Business ( ) _____ Fax ( ) _____ Email _____

34. Physician's Name Last _____ First _____ Middle _____

Address _____ City _____ State ____ Zip _____

Business ( ) Fax ( ) Email

35. Will this physician continue your care if you are admitted? ❑ Yes ❑ No If not, who will:

Name Last _____ First _____ Middle _____

Address _____ City _____ State ____ Zip _____

Telephone: Home ( ) _____ Cell ( ) _____

Business ( ) _____ Fax ( ) _____ Email _____

36. Medicare Part A (Hospital) # _____ Effective date _____

Medicare Part B (Medical) # _____ Effective date _____

Medicare D Prescription Rx Card # _____ Effective date _____

37. Have you applied for CT Medicaid? ❑ Yes ❑ No Is your application ❑ Approved ❑ Pending ❑ Denied

What is your CT Medicaid Claim Number? _____ Effective date _____

Are you receiving New York Medicaid? ❑ Yes ❑ No

38. What other medical insurance do you have?

Company _____ Policy Number/Group Number _____

39. Do you have long-term care insurance? ❑ Yes ❑ No If yes, is it partnership approved? ❑ Yes ❑ No

Company _____ Policy Number/Group Number _____

Please provide copies of all medical insurance cards and Social Security card with your application.

Family Information Continued

Additional Children:

5D Name Last_____ First_____ Middle_____
Mailing Address_____ City_____ State____ Zip_____
Telephone: Home ( ) _____ Cell ( )_____
Business ( )_____ Fax ( )_____ Email_____

5E Name Last_____ First_____ Middle_____
Mailing Address_____ City_____ State____ Zip_____
Telephone: Home ( ) _____ Cell ( )_____
Business ( )_____ Fax ( )_____ Email_____

5F Name Last_____ First_____ Middle_____
Mailing Address_____ City_____ State____ Zip_____
Telephone: Home ( ) _____ Cell ( )_____
Business ( )_____ Fax ( )_____ Email_____

Privacy Information

The information on this application remains confidential. You, your family and friends will receive mailings which include Noble Horizons publications and annual appeals, unless you direct us otherwise.

_____

_____

FOR OFFICE USE ONLY

_____ _____
ADMINISTRATOR DATE

_____ _____
MEDICAL DIRECTOR DATE