NOBLE HORIZONS
A Village of CHI

FOR ADMISSIONS OFFICE USE ONLY

Applicant: _____
last first middle

Placement Date _____ Time _____

_____ _____

Facility: _____

Accommodation _____

_____

Admission Application

Thank you for contacting Noble Horizons 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.**

Please answer all the questions. 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 attach a personal note to this form. After you substantially complete and return this form to Noble Horizons, your name will be placed on our waiting list for admission to the facility.

Receipt # _____

Noble Horizons is a smoke-free 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 the rejection of my application.

Signature of Applicant _____

Signature _____

Relationship to Applicant _____

Please return to: Noble Horizons
17 Cobble Road
Salisbury, CT 06068

Tel: (860) 435-9851 ext. 141
Fax: (860) 435-2323
www.noblehorizons.org

Personal Information

1. Name Last _____ First _____ Middle _____
Mailing Address _____ City _____ State _____ Zip _____
Telephone: Home ( ) _____ Bus.( ) _____ email: _____
Cell ( ) _____ Fax ( ) _____

2. Birthdate _____ Birthplace _____
Social Security # _____

3. Are you ❑ married ❑ single ❑ widowed ❑ divorced
Spouse's Name Last _____ First _____ Middle _____
Spouse's Address _____ 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 _____
Home Mailing Address _____ City _____ State ____ Zip _____
Telephone: Home ( ) _____ Bus.( ) _____ email: _____
Cell ( ) _____ Fax ( ) _____

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

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

*Please use back of application form to list additional children. (list 5D-5F)

In Case of Emergency Notify:

6. Name _____ Relationship _____
Mailing Address _____ City _____ State _____ Zip _____
Telephone: Home ( ) _____ Bus.( ) _____ email: _____
Cell ( ) _____ Fax ( ) _____

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

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 _____
Address _____ Zip _____
Telephone ( ) _____ email:_____
Cell ( ) _____ Fax ( ) _____

16. Who is your attorney?

Name Last _____ First _____ Middle _____
Address _____ Zip _____
Business ( ) _____ email: _____
Cell ( ) _____ Fax ( ) _____

17. Does anyone hold: ❑ Power of Attorney ❑ Conservator of the Person ❑ Conservator of the Estate
If yes, please fill out the following and <u>provide copies with your application</u>:
Name Last _____First _____ Middle_____
Home Mailing Address _____City _____ State ____ Zip_____
Telephone: Home ( ) _____Bus.( ) _____email: _____
Cell ( ) _____Fax ( ) _____
Name Last _____First _____ Middle_____
Home Mailing Address _____City _____ State ____ Zip_____
Telephone: Home ( ) _____Bus.( ) _____email: _____
Cell ( ) _____Fax ( ) _____

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 <u>Confidential</u> 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. _____

other: _____

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. Have you sold, transferred or gifted any significant assets in 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: Bus. ( ) _____ email: _____ Fax ( ) _____

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 ( ) _____ Bus.( ) _____ email: _____

Cell ( ) _____ Fax ( ) _____

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 a psychosocial disorder?

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

33. Can you care for yourself completely and without assistance? ❑ Yes ❑ No If not, what assistance do you need? _____

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

Address _____ City _____ State ____ Zip _____

Business ( ) _____ email: _____

Fax ( ) _____

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 _____

Business ( ) _____ email: _____

Fax ( ) _____

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 _____

*[Please provide copies of all medical insurance cards and Social Security cards with your application.]

(over➔)

Family Information Continued

Additional Children:

5D Name Last _____First _____ Middle_____
Home Mailing Address_____City _____State _____ Zip _____
Telephone: Home ( ) _____Bus.( ) _____email: _____
Cell ( ) _____Fax ( ) _____

5E Name Last _____First _____ Middle_____
Home Mailing Address_____City _____State _____ Zip _____
Telephone: Home ( ) _____Bus.( ) _____email: _____
Cell ( ) _____Fax ( ) _____

5F Name Last _____First _____ Middle_____
Home Mailing Address_____City _____State _____ Zip _____
Telephone: Home ( ) _____Bus.( ) _____email: _____
Cell ( ) _____Fax ( ) _____

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