Application for Admission

and Resident Profile

RIVERVIEW LODGE

RESIDENTIAL CARE HOME

www.riverviewlodge.com

10 Prospect Street

Deep River, CT 06417

860-526-4941

Fax: 860-526-3814

Email: Jim@RiverviewLodge.com

Helping Adults Overcome Challenges since 1967

Resident Application and Information

Note: Please fill out completely. Admission may be delayed or denied if incomplete. Please contact us if you need assistance.

Date of Application: ___________________

PERSONAL

Name: ____________________________ Phone: _______________ Email:________________

Age: ______ D.O.B.: ____________ City/State of Birth: _______________________________

Mother's Maiden Name: _______________________________________

Marital Status: ___________________ Religion: ___________________

Social Security #:_____-_____-______ Medicare#:_______________ Medicaid # _______________

Current Living Arrangement and Address : ____

____From:_____to ______

Previous Address: ____ From:_____to ______

Highest Grade Completed and Location: ____

Conservator of Person: ____________________________________ Phone: ____________________

Address: ____

Conservator of Estate: __________________________________ Phone: ____________________

Address: ____

Power of Attorney:_____________________________________ Phone: _______________________

Address: ____

Emergency contact:_____________________________________ Relation: _____________________

Address: ____

Phone:________________ Cell: _________________ Email: ___________________________

Case Manager/Organization/Phone: ____

How Were You Referred to us: ____

Preferred Date of Admission: _______________________

Does the applicant give permission to Riverview Lodge Residential Care Home to perform a background inquiry for the purposes of this application? Yes_____ No____

FINANCIAL Questionnaire

Who will be responsible for payment of Room and Board to Riverview Lodge RCH?

Name: ____

Billing Address: ____

Does the Applicant have resources to pay rent charges for a minimum of 12 months? ___________

Please list all sources of income and amounts for each:

Soc. Sec.: $ _______________ S.S.I.: $_______________ Other: $__________________

Do the applicant's current resources exceed $1600.00 ? ______________

Please list all assets including vehicles (make/model/year): _____________________________

Does the applicant have a Checking or Savings Account, Trust Fund, Pre-Paid Funeral Contract,

Life Insurance Policy or any Other Assets? ____

*Please list all account #'s: ____

____

*(Note DSS Applications will require a minimum of 2 years statements and must be submitted w/ application)

Has the applicant transferred or sold any Real Estate, Automobiles or other assets in the previous

(36) Months? ____

Has the applicant applied for State Supplement with the Dept. of Social Services? ___________________

Dept. of Social Services Worker: ____________________________ Phone: ______________________________

Community Case Management/Social Work Info

Please list name, organization, address and phone number-

Case Managers: ____

____

____

APPLICANT ROUTINE

Does applicant smoke? _________ Hobbies or interests: ____

____

Usual bedtime_________ Awakening Time ___________

MEDICAL (Note: The Medical and Pertinent History sections of this application must be reviewed and signed by the applicant's physician.)

Physicians name:_____________________________________ (Field) _______________ Ph# __________________

Physicians name:_____________________________________ (Field) _______________ Ph# __________________

Psychiatrist name: __________________________________(Agency) _______________ Ph# __________________

Clinician/Therapist name: ____ Ph# __________________

Is the applicant ...

Compliant with medication?	Yes	No
Continent of bowel and bladder?	Yes	No
Capable of reasonable understanding and direction?	Yes	No
Capable of using public transportation for medical appointments?	Yes	No

If you answered "No" to any of the above questions, please explain: _______________________________________

____

____

Does the applicant...

Need assistance with bathing or dressing?	Yes	No
Have any infectious disease?	Yes	No
Display any inclination to wander?	Yes	No
Been diagnosed with a psychiatric illness?	Yes	No
Have a past or present history of drug or alcohol abuse?	Yes	No
Have any history of violent or inappropriate behavior?	Yes	No
Pose any danger to themselves or others?	Yes	No
Have a Criminal History or ever been arrested for a crime?	Yes	No

If you answered "Yes" to any of the above questions, please explain: _______________________________________

____

____

Special Dietary Needs: ____

Allergies: ____

Current Height: _______________ Current Weight: ________________

MEDICAL (continued)

*Date of most recent Physical Examination: _______________

*Last PPD and results: __________________(***purified protein derivative** (**PPD**) skin **test** is a **test** that determines if you suffer from tuberculosis (TB); *Please attach copy or request to have Dr. send us a copy.

*Date of last flu shot: ___________________ Ever had a Pneumo shot: Yes / No (Date: ________________)

* Please attach a copy of last physical, PPD result and immunization records with this application or request from your Doctor as soon as possible. Please forward to Riverview Lodge at Fax #: 860-526-4941

Diagnosis/Pertinent History (please provide info below and we may request history from proviers):

____
____
____
____
____
____
____

Medications:

(Please list all medications, doses and indicate the reason the applicant is prescribed the medications listed below)

____
____
____
____
____
____
____

Please have a medical provider sign below if available. I have reviewed the Medical and Pertinent History portions of this application.

Signed: ____ Date: ____________________

(Physician's Signature)

The information contained in this "Resident Profile" is accurate to the best of my knowledge. I understand that any misrepresentation of the applicant's health, abilities or history may be grounds for discharge from facility.

Applicant's Signature: ____Date: ____________________

Conservator/POA Signatures: ____Date: ____________________

Conservator/POA Signatures: ____Date: ____________________

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Resident's Name: ______________________ Date of Birth: ______________________

Current Address: ______________________ Social Security #: ______________________

I request and authorize ____ to release healthcare information of the resident named above to:

Name/Agency: ____

Address: ____

City: ______________________ State: __________ Zip Code: __________

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ______________________

____

☐ All healthcare information

☐ Other: ____

I further give permission to Riverview Lodge to share information regarding ongoing healthcare and living situation to the following individuals:

Names:

____

____

____

____

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Resident or Representative Signature: ______________________ Date Signed: ______________________

THIS AUTHORIZATION REMAINS IN EFFECT UNTIL WITHDRAWN BY RESIDENT.