# 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 any assistance.

Date of this Application: ______________________________ Preferred Date of Admission: ________________________

**PERSONAL**

Name: _______________________________ Phone: _______________________ Email:_______________________________________

Age: _______ D.O.B.: ________________ Gender:____________ Place of Birth (City & State): _______________________________

Ethnicity (Optional):___________________ Race (Optional):____________________ Best Language Spoken:_______________

Mother's Full Maiden Name: _________________________________________________

*Marital Status: ______________________ Religion: ______________________ Veteran Status: ______________________

(***Note**: If divorced and applying for State Assistance, please provide a copy of your Divorce Decree)

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 Info - Name:_________________________Organization:____________________Phone:________________________

How Were You Referred to us? : ________________________________________________________________________________

Does the applicant give permission to Riverview Lodge 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/room & board charges for a minimum of 12 months? ___________

Please list all sources of income and amounts for each:

Soc. Sec.: $ _____________ S.S.I.: $________________ SS Disability: $______________ Other: $_________________

Do you have a Disability, Blindness or Impairment?__________ If "Yes" please explain:_______________________________

Are you currently receiving Disability Benefits?:_____________ Date benefits started for Disability Claim:________________

Have you applied for Disability and not yet received any benefits? (please provide details):_____________________________

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 accounts & Account #'s: __________________________________________________________________

____________________________________________________________________________________________________

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

Has the applicant transferred or sold any Real Estate, Automobiles or other assets in the previous 36 Months?
(If "Yes" please explain): _____________________________________________________________________

Are you currently receiving benefits from the State of CT or another state?____________________________

if "Yes" please provide details, program and amounts:______________________________________

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

Dept. of Social Services Worker: ____________________________ Phone: ______________________________

**APPLICANT ROUTINE**

Does applicant smoke? _________ Hobbies or interests: ____________________________________________________

Usual bedtime_________ Awakening Time ___________ Special needs, concerns or issues?:____________________________

**MEDICAL** *(Note: The Medical and Pertinent History sections of this application can be completed by the applicant or persons most familiar with the applicant; if possible it should be reviewed and signed by the applicant's physicians or medical providers).*

**Medical Provider Information -**

Physicians name:___________________________________ (Field) ______________________ Ph# _____________________

Physicians name:___________________________________ (Field) ______________________ Ph# _____________________

Psychiatrist name: ________________________________(Agency) ______________________ Ph# _____________________

Clinician/Therapist name: __________________________ (Agency) ______________________ 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

Have you ever been on or currently on a Registered Sex Offender List? Yes No

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

________________________________________________________________________________________________________

Special Dietary Needs: ______________________________________________________________________________

Allergies/Food Allergies: _____________________________________________________________________________

Current Height: ______________ Current Weight: _______________

*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 Pneumonia shot?: Yes / No (Date: ________________ )

* **Note**: Please provide a copy of Primary Care Physician's 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 detailed info below and we may request history from providers)*:**

______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________
______________________________________________________________________________________________

(**Note**: We will need a current Psych/Social History for anyone with a mental health diagnosis)

***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.