APPLICATION FOR ADMISSION
SCOFIELD MANOR
A State-licensed Residential Care Home

PART I: PERSONAL INFORMATION

Applicant's Name____ Age______

Address____

___________________________________ Telephone______________

Date of Birth________________________ Sex_____ Religion______________

Social Security #_____________________ Medicare #______________________

Medicaid #______________________ Other insurance______________________

Physician's Name___________________________ Telephone_______________

Address____

Nearest Relative/Responsible Party______________________________________

Address__________________________________ Relationship_____________

_____________________________________ Telephone______________

Other contact________________________________ Relationship_____________

Address___________________________________ Telephone______________

____

Other contact_________________________________ Relationship____________

Address___________________________________ Telephone______________

____

Does someone hold the applicant's Power of Attorney?

Name____ Telephone_____________

Address____

Does the applicant have a Conservator?

Name_______________________________________ Telephone______________

Address____

PART II: AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I authorize release of medical information pertaining to the above applicant to Scofield Manor.

____ _________________________
Signature of Applicant or Responsible Party Date

PART III: APPLICANT'S FINANCIAL INFORMATION

Name ____ Date________________

INCOME

Social Security $________________/month

Pension $________________/month from___________________________

Annuity $________________/month from___________________________

Interest/Dividends $________________/month from___________________________

Veteran's Benefits $________________/month

Other $________________/month from___________________________

Do you receive income from or have any interest in a trust? Yes____ No____
If yes, please describe and provide a copy of the trust document.

ASSETS

Own home Yes___ No____ Jointly held?______ Value $____________

Other property Yes___ No____ Jointly held?______ Value $____________

Stocks/bonds Yes___ No____ Jointly held?______ Value $____________

Life Insurance Yes___ No____ Jointly held?______ Value $____________

Funeral Insurance Yes___ No____ Jointly held?______ Value $____________

Other Yes___ No____ Jointly held?______ Value $____________

BANK ACCOUNTS

Owner(s) of Account________________________________ Present balance $_______

Bank Name____________________________ Address____________________________

Owner(s) of Account________________________________ Present balance $_______

Bank Name____________________________ Address____________________________

PART IV: TRANSFER OF ASSETS

1. Has the applicant sold or given away a motor vehicle, property, stocks, bonds, cash, or any other significant assets in excess of $1,000 in the past two years?
   Yes___ No___ If yes, please describe.

2. Has any type of trust been established in the last two years prior to this application?
   Yes___ No___ If yes, please describe.

PAYMENT SOURCE

Payment to Scofield Manor for room and board will be made by (check one)

Personal Funds _______

Title 19 (Medicaid) _______ Medicaid Number____________________

SAGA __________ SAGA Number____________________

Unknown___________

Has the applicant applied for Title 19 (Medicaid) Assistance? Yes___ No___

If so, name of intake worker _____________________________ Phone #.__________

I hereby certify that the information submitted in this application is complete and accurate. I understand that misrepresentation is a basis for both denial of admissions or discharge.

____ _______________________
Applicant's Signature Date

____ _______________________
Signature of Responsible Party/Relative Date

THIS SECTION NEEDS TO BE COMPLETED BY A PHYSICIAN

The following form is part of an application to live at Scofield Manor, a residential care home. Scofield Manor is similar to an assisted living facility. It is not a nursing home. We have two attendants on duty 24 hours/day who assist with activities of daily living. In addition, we have an R.N. who provides medication management and wellness checks Monday through Friday from 8:30 a.m. to 3:30 p.m. We also provide 3 meals/day, transportation to medical appointments and daily activities. Scofield Manor promotes maximum independence and dignity for each resident.

It is important that we know the current medical condition of the applicant in order to ascertain if this is a good placement. Please complete the following form and fax it to (203)329-2609.

Applicant's Name____

Current Diagnosis____

Brief description of the applicant's recent health history______________________________

____

____

Does applicant have any infections/communicable disease? ____________________________

If yes, please describe____

Height:___________ Weight:____________ Blood Pressure:___________________________

History of abuse of alcohol?___ Other drugs?_____ How recently?______________________

MEDICATIONS:

DRUG	DOSAGE	FREQUENCY

Can the applicant self-medicate?________

Dietary restrictions:____

Prior hospitalizations and/or surgery:____

____

ACTIVITIES OF DAILY LIVING

Ambulating: Self_______ Cane______ Walker_______ Prosthetic device_____

Feeding: Self_______ With Minimal Assistance______ Needs full assistance_____

Dressing: Self_______ With Minimal Assistance______ Needs full assistance_____

Is the applicant continent of bladder?_______________ Of bowel?______________________

MENTAL STATUS (check as many as apply)

Alert ______ Confused_____ Forgetful_____ Depressed_____ Agitated______

Abusive_____ Withdrawn____ Liable to wander_____

LIMITATIONS

Language Barrier_______ Native Language___________ Speech Impairment____

Hearing: Normal__ Poor___ Has hearing aid___ Should have hearing aid___

Vision: Normal__ Poor___ Has eyeglasses___ Other_____________________________

Eye or ear disease____

Does applicant wear dentures? ______

Allergies____

PPD Date:__________________ Results:______________________

Most recent immunizations:

Flu vaccine ____ Date:________________ Pneumovax____ Date__________________

Other ____________________________ Date_______________________

Other pertinent medical information:____

____

____

____

In your opinion, is this applicant appropriate for a Residential Care Home?_____

While the applicant is residing at Scofield Manor, I will remain as his/her primary physician_____
Hospital with which you are affiliated____

____ Date:____________________

Physician's Signature

Address:____ Phone:___________________

____

For office use only:
Appl.# __________

Program_________

Sent Out_________

STAMFORD HOUSING AUTHORITY
22 CLINTON AVENUE, P.O. BOX 1376
STAMFORD, CONNECTICUT 06904
(203) 977-1400

POLICE RECORD RELEASE WAIVER

DO NOT BRING THIS FORM TO ANY POLICE DEPARTMENT.

PLEASE RETURN THIS FORM TO THE **STAMFORD HOUSING AUTHORITY ONLY**

PLEASE PRINT CLEARLY PLEASE PRINT CLEARLY PLEASE PRINT CLEARLY

LAST NAME: ________________________________ **MAIDEN NAME**: __________________________

FIRST NAME: ________________________________ **MIDDLE NAME:** __________________________

DATE OF BIRTH: _________________ SOCIAL SECURITY #: ____________________________

CURRENT STREET ADDRESS: ____

____ HOW LONG?_________________

CITY STATE ZIP

CURRENT PHONE NUMBERS ____

CHECK BOX BELOW AND LIST INFORMATION ON THE OTHER SIDE IF APPLICABLE:

- ☐ **KNOWN BY ANY OTHER NAME. IF SO, SEE OTHER SIDE**
- ☐ **ARRESTED IN A CITY OR STATE NOT LISTED ON THIS FORM? (OVER)**
- ☐ **IF YOU DID NOT LIVE AT YOUR PRESENT ADDRESS FOR 10 YEARS, PLEASE LIST ADDITIONAL ADDRESSES ON OTHER SIDE**

DO YOU NEED TO ENTER ANY INFORMATION ON THE OTHER SIDE?

I HEREBY *AUTHORIZE THE RELEASE* OF ANY ARREST AND CONVICTION RECORDS THAT MAY EXIST WITH ANY POLICE DEPARTMENT.

I ATTEST THAT I HAVE NOT BEEN ARRESTED IN ANY CITY THAT IS NOT LISTED ON THIS FORM. I ATTEST THAT I HAVE DISCLOSED ALL ADDRESS INFORMATION ON THIS FORM. I AM AWARE THAT MISLEADING INFORMATION IN THIS FORM MAY LEAD TO DENIAL OF MY APPLICATION.

SIGNATURE ___________________________________ DATE ______________________________

FOR POLICE DEPARTMENT USE ONLY:

CHECKED BY: ______________________________________ DATE CHECKED: _______________

CRIMINAL RECORD: (   ) YES (   ) NO

OTHER NAMES IF APPLICABLE:

LAST NAME: ________________________________

FIRST NAME: ________________________________ MIDDLE NAME: ___________________________

LAST NAME: ________________________________

FIRST NAME: ________________________________ MIDDLE NAME: ___________________________

PREVIOUS ARREST HISTORY IN OTHER CITIES OR STATES

DATE: ______________________ ________________________________ CITY STATE

DATE: ______________________ ________________________________ CITY STATE

DATE: ______________________ ________________________________ CITY STATE

DATE: ______________________ ________________________________ CITY STATE

DATE: ______________________ ________________________________ CITY STATE

PREVIOUS ADDRESSES

PREVIOUS ADDRESS: ____ STREET

____ HOW LONG?_________________
CITY STATE ZIP

PREVIOUS ADDRESS: ____ STREET

____ HOW LONG?_________________
CITY STATE ZIP

PREVIOUS ADDRESS: ____ STREET

____ HOW LONG?_________________
CITY STATE ZIP

TO ALL INCOMING RESIDENTS

SCOFIELD MANOR APPROVAL AGREEMENT

I, ____, am in agreement that upon notification from the Department of Social Services (DSS) indicating that I am ineligible to receive Title XIX Supplemental Subsidy, this notice will result in my being Discharged the next day from Scofield Manor.

I further acknowledge that Scofield Manor will have no further obligation to the resident once he/she is discharged.

I agree to the terms and conditions of the above regarding Title XIX Ineligibility.

Name of Resident ______________________________________

Signature ______________________________________

Date ______________________________________