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:_____

_____

SCOFIELD MANOR MEDICAL ADMISSION FORM

TO BE FILLED OUT BY THE PHYSICIAN.

NAME:_____

DOB:_____ ALLERGIES: _____

MEDICATION	ROUTE	DOSE	FREQUENCY

DOCTOR'S NAME: _____

SIGNED:_____ DATE:_____

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 _____