DOUGLAS MANOR

Nursing and rehabilitation Center
Located at: 103 North Road Windham, CT 06280

RYDERS HEALTH MANAGEMENT

Thank you for considering our home for your loved one's care.

Attached are the following applications:

Long-Term Care Application

With Financial Application

Please Fill out pages 2-10 fully, sign, and return to:

Maria Carvajal-Krupula LPN
Admissions/ Marketing Director
Please feel free to contact me at
Phone: 1-203-209-0499
Email: mkrupula@douglasmanor.net
With any questions regarding the attached applications

Douglas Manor
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103 North Road Windham, CT 06280
Tel: (860) 423-4636 Fax: (860) 423-5105
www.rydershealth.com

GOVERNING BODY
Martin Sbriglio, RN, NHA Consultant
Dr. Robert Sbriglio, MD MPH, NHA
Chief Medical Officer
Douglas Manor | Facebook

Application for Short- Term Rehabilitation/ Care Admission

First, Last Name:_____ Preferred Name:_____

Current Address:_____ City/State:_____

Zip Code:_____ Date of birth:_____ Age:_____ Place of Birth City/ State:_____

Telephone number: _____ Sex at Birth: Male / Female Marital status: _____

First, Last Name of Spouse: _____ Social Security number: _____

Registered voter: Yes / No. If yes name of City/ State: _____ Zip code: _____

Religious Preference: _____ Education: _____ Current/ Former Occupation: _____

Current/ Former Employer: _____ Date of Retirement:_____

Name of current Physician:_____ Address of Physician: _____

Veteran: Yes / No. Is spouse a Veteran: Yes / No.

First/ Last name of Children and current address:

_____
_____
_____
_____
_____

First/ Last name, relation, and current address of family members involved in care:

_____
_____
_____
_____

Check off all the appropriate choice for the applicants former living arrangements:

Alone: _____Home: _____ Assisted living:_____ Care services in place:_____ Spouse at home:_____ Family at home:_____
Other please provide specifics: _____

History of unprescribed drug dependence: Yes / No. History of Alcohol dependence: Yes / No.

If yes you marked yes to drug dependence or alcohol dependence, please provide details to drug name/ usage and/ or alcohol consumption (What and how much a day):

_____
_____
_____

History of mental illness:

_____
_____
_____

Any noted emotional issues (Anger, depression, mood changes)? If yes, please provide details:

_____
_____
_____

Recent loss of a loved one in the last year? If yes, please provide details:

_____
_____
_____

How does the applicant feel about placement at Douglas Manor for Short-term rehabilitation/ care (Accepting, denial, angry, indifferent, unsure)? Please provide details below:

_____
_____
_____

What are the current plans in place to transition the applicant from short-term rehabilitation/ care to community (assisted living, home alone, home with services, home with family)? Please provide details:

_____
_____
_____
_____

Current insurance information for applicant:

Medicare member ID number:_____

Managed Medicare ID number and Carrier (UHC, Connecticare, Anthem, Aetna):

_____

Supplemental/ Part B member ID and Carrier (VA, Tricare, UHC, AARP):

_____

Other insurance member ID/ Carrier:_____

Name of the Desired Funeral Home: _____ Phone number: _____

Person Responsible for Applicants Account:

First, Last Name:_____

Address:_____

City/ State:_____ Zip Code:_____

Home Phone number:_____ Cell phone Number:_____

Email address: _____

Relation to applicant: _____ Are you POA: Yes / No. Are you Conservator: Yes / No.

Emergency Contacts:

1. FIRST, LAST NAME AND RELATION TO APPLICANT:
   _____

Address:_____ City// State:_____

Zip Code:_____ Home phone number_____ Cell phone Number:_____

2. FIRST, LAST NAME AND RELATION TO APPLICANT:
   _____

Address:_____ City// State:_____

Zip Code:_____ Home phone number_____ Cell phone Number:_____

3. FIRST, LAST NAME AND RELATION TO APPLICANT:
   _____

Address:_____ City// State:_____

Zip Code:_____ Home phone number_____ Cell phone Number:_____

Medical History

Primary Diagnosis: _____

Is the individual aware of health status: Check the appropriate answer: Yes: _____ No: _____

Previous nursing home admissions: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

Currently Hospitalized: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

Current or previous psychiatric hospitalizations: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

Is the applicant on Hospice services? Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

Is the applicant on Antipsychotic medications: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

Is the applicant on Antidepressant or antianxiety medications: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

Any known drug allergies: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

Is the applicant on Chemotherapy medications: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

Has the applicant had any recent operations: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

Present location of applicant: _____

How long has the applicant been at present location:_____

Reason for placement at present location:_____

Information Pertaining to applicant's personality and lifestyle:

Recent activities:_____

Volunteer activites:_____

Interests/ Hobbies:_____

Special talents:_____

Dislikes:_____

Favorite tope of conversation: Check the appropriate answer:

Family:_____ Grandchildren: _____ Sports: _____ Past events: _____ Other:_____

If above answer is other please provide details:

_____

_____

_____

Applicants current function levels

Current mental status: Check the appropriate answer/ answers:
Alert: _____ Confused: _____ Oriented: _____ Disoriented: _____ Aggressive: _____ Combative: _____

Code status: Check the appropriate answer/ answers:
DNR: _____ DNI: _____ Resuscitate: _____ has living will: _____

Nursing information

Ambulation: Check the appropriate answer/ answers:
_____ Independent with or without assistive device
_____ Walks with supervision with or without device
_____ Walks with continuous physical assistance or support
_____Bed to chair with mechanical device (Non-ambulatory)
_____ Bedfast
May describe ambulation ability in more detail here:_____

Transferring: Check the appropriate answer/ answers:
_____ No assistance
_____ Uses assistive device with on hands on assistance (walker or cane)
_____ Supervision only
_____Requires transfer with or without equipment with assistance
_____ Bedfast
May describe Transferring needs in more detail here:_____

Bladder: Check the appropriate answer/ answers:
_____ Continent
_____ Rarely incontinent (during night only)
_____ Occasionally incontinent (once a week or less)
_____ Frequently incontinent (up to once a day)
_____ Totally incontinent
_____ Has urinary catheter
May describe bladder needs in more detail here:_____

Bowel: Check the appropriate answer/ answers:
_____ Continent
_____ Rarely incontinent (during night only)
_____ Occasionally incontinent (once a week or less)
_____ Frequently incontinent (up to once a day)
_____ Totally incontinent
_____ Has ostomy
May describe bowel needs in more detail here:_____

Bathing: Check the appropriate answer/ answers:
_____ No assistance
_____ Supervision only
_____ Assistance in/ out of tub/ shower with light hands on assistance while bathing
_____ Requires total care by caregiver for tub/ shower
May describe bathing needs in more detail here:_____

Dressing: Check the appropriate answer/ answers:
_____ No assistance
_____ Supervision only
_____ Light hands on assistance while dressing
_____ Requires total assistance from care giver to get dressed
May describe bathing needs in more detail here:_____

Feeding: Check the appropriate answer/ answers:
_____ No assistance **Does the applicant have Dentures: Yes / No**
_____ Supervision only
_____ Light hands on assistance/ verbal ques
_____ Requires total assistance from care giver to eat
May describe bathing needs in more detail here:_____

Sight: Check the appropriate answer/ answers:
_____ Good **Does the applicant have glasses: Yes / No**
_____ Vision is adequate- unable to read fine print
_____ Vision is limited- Gross object differentiation
_____ Blind
May describe vision needs in more detail here:_____

Hearing: Check the appropriate answer/ answers:
_____ Good **Does the applicant have hearing aids: Yes / No**
_____ hearing slightly impaired
_____ Limited hearing- must speak loudly
_____Virtually/ completely deaf
May describe hearing needs in more detail here:_____

Speech: Check the appropriate answer/ answers:
_____ Speaks clearly
_____ Some deficits- usually gets message across
_____ Unable to speak clearly or not at all
May describe speech needs in more detail here:_____

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Financial Evaluation

First, Last name of applicant:_____

Applicant is admitting from: _____Responsible party: _____

Home phone number: _____ Cell phone number: _____

Address:_____

City/ State:_____ Zip Code:_____.

Insurance information:

Medicare Number: _____ Medicaid number: _____

Pending T-19 application number: _____ Date and District applied:_____

Case workers name:_____

Case workers Phone number: _____

Case workers E-mail address: _____

Is applicant a private pay? Check off appropriate answer: Yes: _____ No: _____

Length of time applicant will be maintained as private pay:_____

Is the applicant a Veteran? Check the appropriate answer: Yes: _____ No: _____

Is the applicant's spouse a Veteran? Check the appropriate answer: Yes: _____ No: _____

Does the applicant own a Partnership- approved Long-Term Insurance policy? Check the appropriate answer: Yes: ____ No: _____

If the above answer is yes, What is the policy number: _____ Name of Carrier:_____

Amount of policy: _____ Phone number for policy: _____

Other health insurance:

Type: HMO: _____ Group:_____ Major Medical: _____ No Fault: _____ COBRA: _____

Company name: _____ Policy Number: _____

Company name: _____ Policy Number: _____

Company name: _____ Policy Number: _____

Coverage Notes:

_____

_____

_____

Applicants own income:

Social Security: $_____ per month.

Mailed to provide address, city, state, and zip code: _____

_____

Direct Deposit into Checking account: Yes / No. Direct Deposit into Savings account: Yes / No.

Amount of Pension: $_____ per month. Source: _____

Amount of Annuity: $_____ per month. Source: _____

Amount of Interest: $_____ per month. Source: _____

Dividends: $_____ per month. Source: _____

Other: $_____ per month. Source: _____

Does the applicant receive income from or have any interests in a Trusts? Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

_____

Does the applicant have any debt or obligations: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

_____

Does the applicant have any pending lawsuits filled or planned that might result in receipt of payment: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

_____

Applicants assets:

Does the applicant have Real Estate; Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide address, city, state, and Zip Code:

_____

_____

Name:_____

Description: _____

Was this Real Estate the applicant's home prior to entering the facility: Check the appropriate answer: Yes: _____ No: _____

Is the applicants spouse now living in the home: Check the appropriate answer: Yes: _____ No: _____

Does the applicant have "Life Use" of any real estate, any ownership interests (in full or part) for his/ her lifetime, or the right to occupy property for his/ her lifetime: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details:

_____

_____

Does the applicant own any Automobiles or Vessels: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes, please provide details:

Make and Model: _____ Year: _____ Owner/s:_____

Make and Model: _____ Year: _____ Owner/s:_____

Make and Model: _____ Year: _____ Owner/s:_____

Does the applicant own any Stocks and/ or Bond Certificates: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details(Describe type and approximate value):

_____

_____

Does the applicant own any Bank, Savings, or checking accounts: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details(Describe type and approximate value):

_____

_____

Does the applicant have any life insurance policies: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details(Describe type and approximate value):

_____

_____

Does the applicant have any other policies or assets of value not listed above: Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please provide details(Describe type and approximate value):

_____

_____

Does the applicant have any Burial or Agreement accounts Check the appropriate answer: Yes: _____ No: _____

If above answer is yes, please provide details:

Name of Funeral Home: _____ Amount: _____ Revocable: Yes / No. Irrevocable: Yes / No.
Name of Owner: _____

Name of Funeral Home: _____ Amount: _____ Revocable: Yes / No. Irrevocable: Yes / No.
Name of Owner: _____

Name of Funeral Home: _____ Amount: _____ Revocable: Yes / No. Irrevocable: Yes / No.
Name of Owner: _____

Name of Funeral Home: _____ Amount: _____ Revocable: Yes / No. Irrevocable: Yes / No.
Name of Owner: _____

Transfer of assets:

Within (60) sixty months prior to the date of this application, has the applicant or the applicant's spouse given away any assets of any kind (E.g. Cash, security checks, real estate, etc.) or transferred any assets of any kind for less than fair market value?

Check the appropriate answer: Yes: _____ No: _____

If above answer is yes please describe fully all such gifts and/or transfers in excess of $1,000 including the asset transferred, names, addresses, and relationship of the person to whom the gift or transfer was made to and the value of the gift and/ or transfer:

_____
_____
_____

Within (60) sixty months prior to the date of this application, has the applicant or the applicant's spouse created any trusts and/ or placed funds and/ or any other assets in a trust that already existed?

Check the appropriate answer: Yes: _____ No: _____

If above answer is yes, please describe and provide a copy of the trust instrument:

_____
_____
_____
_____

I certify that I have fully investigated the applicants financial records and that this is a true and complete statement of the applicants current income, assets, any gifts, any transfers of less than the fair market value in excess of $1,000, any trusts created, and or transfers of assets to any trust that the applicant and/or his/ her spouse has made.

_____ _____

Name of Patient/ Resident/ Responsible party Date

that filled out the Financial evaluation

_____

Signature of Patient/ Resident/ Responsible party

that filled out the Financial evaluation

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Douglas Manor Cost Sheet

The following costs are for individuals paying privately (Not utilizing insurance)

Room and board

Daily rate for private: $432.00 a day

Daily rate for Semiprivate: $412.00 a day

Note daily rate includes: Room/ board, cable TV, local telephone calls, laundry, 24/7 medical staff/ care.

In addition to daily room rate provided above, the below services are paid at a per- diem rate

Speech, Occupational, and/ or Physical therapy evaluations: $80.00 for 15 minutes

Speech and/ or Occupational therapy session: $60.00 for 15 minutes

Physical therapy session: $40.00 for 15 minutes

Services as rendered

Physician

Pharmacy

Laboratory

X-ray

Oxygen

Podiatry

Dental

Audiology

Psychiatric

Thank you for considering Douglas Manor for your loved ones short-term and/ or long-term care needs. If you have any questions, please contact any of the following for further assistance:

Facility administrator: James Lopez, LNHA- 860-423-4636 ext. 2111

Facility admissions and marketing director: Maria Carvajal-Krupula, LPN- 860-423-4636 ext. 2107