Sheltering Arms
165 McKinley Avenue
Norwich, CT 06360
860-887-5005
860-892-2340 fax

APPLICATION FOR ADMISSION

Date Received: ________________

Name: ____________________________________________________________________
Current Address: _________________________________________________________
If Medical facility/Name of Facility:_______________________________________
How did you hear about us? ________________________________________________

Date of Birth: ________________
Religion: ____________________
Marital Status: _______________
Name of Spouse: _____________

Number of children: ___________________
Names/Address of children :
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Names /Address of Siblings:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Primary Contact Person: ___________________ Relationship: ____________________
Address: _____________________________________________________________
Home telephone #:__________ Work number ___________Cell number: __________
Email : _______________________________
Secondary Contact Person: _________________Relationship: ____________________
Address: _____________________________________________________________
Home telephone #:__________Work number:___________ Cell number: __________
Email: _________________________________

Employment/Education:
Former Occupation:_______________________________________________________
Highest Level of Education completed: _______________________________________
Languages spoken: _____________________________
Hobbies and Interests:____________________________________________________
Special Talents: __________________________________________________________

Primary Care Physician: ______________________________
Does Applicant Require any assistance with any of the following:
Bathing ____ Dressing ____ Medication Administration ____ Personal Hygiene ______
Are there any problems with Incontinence? Bladder ______ Bowel _______
Does applicant wear pads or undergarments for incontinence?
Never ____ Always _____

Financial information: This information will be kept Confidential

Payment Method: Private Pay ______________ Medicaid (Title#19) _____________
Name/Address of Person Responsible for your Billing: __________________________________
__________________________________________________________________________________

Income:
Social Security: __________________
Pension: ________________________
VA Benefit: ____________________
SSI: ___________________________
Interest Income: __________________
Other Income: ___________________

Social Security number: _______________________
Insurance Information:
Medicare Number: ___________________________
Medicaid Number: _________________________ Caseworker: __________________
Is Medicaid application still pending? Yes _______ No _____________

Medical Insurance Company & Subscriber Number:
_________________________________________________________________________

Life Insurance: Yes _________ No ___________
If yes: Company & Amount _______________________

Other Info:

Do you have a prepaid funeral account? Yes ____ No _____
If yes what funeral home: ____________________________________

The following will need to be provided upon admission if applicable:
Medicare Card
Social Security Card
Insurance Card
Living Will documents
Power of Attorney documents
Conservatorship documents