Waveny LifeCare Network

Leading Fuller Lives

Application to be completed by applicant or authorized representative

Please print, Thank you

RESIDENCE, SERVICE, PROGRAM OR FACILITY REQUESTED *(please select)*

❑ **Short-Term Rehabilitation**
Waveny Care Center

_____
Surgery Date Hospital

❑ **Long-Term Skilled Nursing Care**
Waveny Care Center

❑ **Long-Term Special Care Unit**
for cognitive impairment
Waveny Care Center

❑ **Assisted Living***
The Village

❑ **Long-Term Care**

❑ **Short-Term Respite Care**

❑ **Adult Day Program**

❑ **Independent Living***
The Inn

* All applicants to The Village and The Inn are automatically placed on Waveny's long-term care wait list should the need arise at a later date.

APPLICANT INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ Sex: ❑ Male ❑ Female

Marital Status: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

Occupation (Current or Former): _____

Religious Affiliation (optional): _____

Social Security #: _____

Medicare #: _____

Medicaid #: _____

Other Insurance #: _____ Type: _____

* Copies of all cards (Social Security, Medicare/Medicaid, Insurance) must be provided before or upon admission.

NEXT OF KIN/EMERGENCY CONTACT

Name: _____

Relationship: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____ Business Phone: _____

ADDITIONAL INFORMATION

Does the applicant have Advanced Directives? ❑ Yes* ❑ No

*If yes, check all that apply: ❑ Power of Attorney ❑ Living Will ❑ Health Care Agent ❑ Conservator
*Please provide documentation before or upon admission.

Is the applicant a veteran: ❑ Yes ❑ No Serial Number: _____

Has the applicant ever been treated or cared for at Waveny LifeCare Network or an affiliate? ❑ Yes ❑ No

If yes, in what capacity: _____

Has the applicant ever been a New Canaan resident? ❑ Yes ❑ No

Has a relative of the applicant ever resided in New Canaan? ❑ Yes ❑ No

If yes, Name: _____ What year(s): _____

Relationship: _____

New Canaan Address: _____

Where is the applicant living at this time? _____

PRIMARY CARE PHYSICIAN

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

SECONDARY PHYSICIAN/SPECIALIST

Name: _____

Address: _____

Specialty: _____

City: _____ State: _____ Zip: _____

Phone: _____

ATTORNEY

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

_____ _____

Signature of applicant or authorized person **Date**

FOR INTERNAL OFFICE USE ONLY

Dx: _____

Dx: _____

Med. Record #: _____ Room #: _____

Date of Application: _____

FINANCIAL APPROVAL:

CFO Signature: _____ Date: _____