



Matulaitis Nursing Home

Rehabilitation & Hospice Care

10 Thurber Road • Putnam, CT 06260

T: 860-928-7976 • F: 860-963-1920

Email: admissions@matulaitisnh.org • www.matulaitisnh.org

Welcome

You have contacted this nursing home and indicated a desire to be admitted as a patient to this facility. Because of this, you have already been issued a receipt indicating the date and time of your initial request and your name has been placed on our dated list of application or inquiry list.

Please find enclosed this facility's written application form. As soon as you complete and return the form to the facility, your name will be placed on our waiting list for admission to the facility. Your name will only be placed on our waiting list after you complete and return this written application to us.

**Thank You,
Matulaitis Nursing Home**



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Admission Policy and Procedure

It is the policy of Matulaitis Nursing Home to admit and treat all residents without regard to race, national origin, religion, sex, age or financial status.

Matulaitis Nursing Home is licensed by the State of Connecticut Public Health Department as a Nursing Home for Chronic and Convalescent Care – Skilled Nursing Facility.

Persons interested in having prospective residents considered for admission to the facility should obtain the "Application for Admission," the "Preadmission Physical Examination," the "Authorization for Release of Information," the receipt of Matulaitis Nursing Home's "End of Life Policy" and the "Transfer of Assets" forms from the social worker or the administrator.

It is only when all five forms have been completed and received by the facility that eligibility for admission will be evaluated by the Admission Committee.

After the Admission Committee has reviewed the information received, a letter will inform the interested party of the Committee's decision. If the Committee determines that appropriate services can be provided by Matulaitis Nursing Home, the prospective resident will then be considered an "applicant." The letter will verify the date and time of the applicant's placement on the waiting list.

If an applicant's physical condition changes significantly during the time awaiting admission, the facility should be notified and an additional "Preadmission Physical Examination" form should be completed and filed with the facility.

Applicants on the waiting list are offered admittance to Matulaitis Nursing Home in order as vacancies occur. An applicant offered admission must be seen by his/her physician within 30 days prior to admission.



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Release of Information

Today's Date _____

To Whom it May Concern:

I, _____, authorize the release to, and the use by, **Matulaitis Nursing Home of any medical and psychiatric or other pertinent information needed in providing continuity of care for my welfare.**

Signature _____



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Transfer of Assets

Resident name: _____

Have you (or your spouse) sold, traded, given away, or transferred ownership of any motor vehicles, bank accounts, property of any kind, stocks, bonds, mutual funds or cash during the past 36 months?

Yes No

Have you (or your spouse) sold, traded, given away, or transferred ownership of any motor vehicles, bank accounts, property of any kind, stocks, bonds, mutual funds or cash during the past 60 months?

Yes No

Have you (or your spouse) established a trust or funded a trust with income or property of any kind within the past 60 months?

Yes No

If yes, provide addition details (attach additional pages if needed.)

Have you (or your spouse) closed any type of account during the last 36 months?

Yes No

If yes, explain below. Include the bank name, address, account number and date closed.

Resident's signature _____ Date _____

Resident's representative or legal representative _____ Date _____

Facility witness signature _____ Date _____



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Policies and Procedures

On Death and Dying

Matulaitis Nursing Home as a Christian institution is guided by the perennial teaching of the Catholic Church concerning the value of human life and the obligation to preserve it.

Christian View of Life and Death

Human life is God's creation – God's gift to each of us. We cannot decide to take our own life or the life of other human beings, or to make an arbitrary decision whether the life of an individual person is meaningful or not. We must reverence all human life and work to preserve it.

In the Christian view, death is not a final end of an individual's existence, but a necessary "passage" to a new and eternal life. Death, then, is an event, both painful and glorious, that calls for preparation and for spiritual as well as medical care.

Preserving Life

We have a duty to preserve our life until we are called to eternity. The use of life sustaining technology is judged in the light of the Christian meaning of life, suffering and death. The duty to preserve our life is not absolute for we may reject life-prolonging procedures that are insufficiently beneficial or excessively burdensome. All efforts are made so that a person may die comfortably with compassion and dignity. Assisted suicide or euthanasia is never morally acceptable. Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering.

Guidelines for Decisions

Physicians and their patients must evaluate the use of technology at their disposal. Reflection on the innate dignity of human life in all its dimensions and on the purpose of medical care is indispensable for formulating a true moral judgment. The task of medicine is to care even when it cannot cure and to keep the person as free of pain as possible.

A person has a moral obligation to use ordinary or proportionate means to preserve his/her life. Proportionate means are those that offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense.

Extraordinary or disproportionate means are those that do not offer a reasonable hope of benefit or entail excessive burden or impose excessive expense. A person may forgo extraordinary means of preserving life. The primary decision to use or not to use extraordinary means is that of the patient. When a person is unconscious or otherwise not capable of making such a decision, a family may decide dependent on the presumed will of the patient, or a person who has a durable power of attorney, or a responsible party guided by an Advance Directive for Health Care and Treatment.

Explanation of Ordinary Means

In the moral sense, ordinary means are: oxygen, nutrition and hydration, including medically assisted nutrition and hydration, except for a person who is immediately dying or the means cannot be assimilated by a person's body. Also included are medicines, including medicines to relieve pain, antibiotics to control infection, etc.; treatments such as I.V. therapy, blood transfusions, etc.; and operations such as would give hope and benefit the patient to continue to live, as much as possible a normal life. Hospital transfer does not indicate extraordinary means. It may be necessary for acute care, emergency care or even complicated diagnostic tests.



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Death & Dying Policy

I have read and understand Matulaitis Nursing Home’s “On Death and Dying” policy, and agree to comply with the philosophy of the nursing home on behalf of

Name of Applicant: _____

I also understand that this policy supersedes any living will presented upon admission that is in conflict with the policy of the nursing home.

Date: _____

Signature of applicant or authorized representative _____



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Application for Residency

Applicant Information

First Name: _____ Last Name: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Telephone: () _____ Email: _____

Date of Birth: _____ Place of Birth: _____ Citizen: Y N

Religion: _____

If Married, Widowed or Divorced: _____

Mother's Maiden Name: _____ Birthplace: _____

Father's Name: _____ Birthplace: _____

Nearest Relative, Guardian or Friend: _____

Relationship to Applicant: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Telephone: () _____ Cell: () _____

Email: _____

Is Anyone Legally Authorized to Act for You? Y N Who? _____

Former Occupation: _____

Hobbies: _____

Applicant Personal Information

Social Security No: _____ Medicare No: _____

Medicare RX Company: _____ Medicare RX ID No: _____

Medicaid No: _____ Veteran's No: _____

Blue Cross (Blue Shield) No: _____ Other Insurance: _____



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Application for Residency

Confidential Information *Please list all potential payment sources (including income/assets)*

Savings: _____

Real Estate: _____

Life Insurance: _____

Social Security Amount: _____

Any other Pensions? _____

Who will be responsible for payments?: _____

Will you be eligible for State’s medical assistance program (Title XIX) within 180 days of admission?

Y N

Burial Arrangements

Do you have a prepaid burial contract? Y N Undertaker: _____

Church: _____

City/Town: _____ State: _____

Cemetery: _____

City/Town: _____ State: _____

In case of death who will be responsible for funeral? _____

Telephone: () _____ Email: _____

Person to be notified about acceptance: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Telephone: () _____ Email: _____

Signature

Applicant or Responsible Party _____ **Date:** _____

The above applicant will be on our waiting list as soon as we receive the completed forms.

Complete application received? Y N Date Received: _____



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Preadmission Health Assessment Profile

Applicant's Name <i>(Last, First, Middle)</i>	Sex	Birthdate	Marital Status	Last Exam
Address <i>(Street, City, Zip Code)</i>				Home Phone
Physician's Name		Address		Phone No

Hospitalizations

Hospital	Dates	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

Active Problems

(Include Dental, Podiatric, Psychological)

Active Problems	Date of Onset	Disability Level <i>(None, Moderate, Severe)</i>
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Pertinent Lab:

Vital Signs: P. _____ BP _____ WT _____ Diet _____	History of Depression? Y <input type="checkbox"/> N <input type="checkbox"/>
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Mental Status:

Alert/Oriented _____
 Confused _____
 Confused at times _____
 Disoriented _____
 Unresponsive _____
 Comatose _____
 Inappropriate behavior _____

Wanders? Y N
 Sleeps All night? Y N
 Wakes Intermittently? Y N
 Psychiatric History? Y N



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Preadmission Health Assessment Profile

Rehab Plan/Therapeutic Goal: Good Fair Poor Indeterminate

Self Care Status				Impairments		Physical Therapy Needed?	
						Y <input type="checkbox"/>	N <input type="checkbox"/>
Independent	Needs Assistance	Unable			Occupational Therapy Needed?		
				Y <input type="checkbox"/>	N <input type="checkbox"/>		
Bed-Chair				Speech			
Walking				Hearing			
Stairs				Vision			
Wheelchair				Recent Memory		Social Services <i>(Information adjustment to disability)</i>	
Crutches				Remote Memory			
Walker				Glasses			
Cane				Amputation			
Bathe Self				Paralysis		Pneumovax: Y <input type="checkbox"/> N <input type="checkbox"/>	
Feed Self				Contractures		Date:	
Brushing Teeth				Skin		Bowel	Bladder
Shaving				Decubitus & Size		Continent	
Toilet						Incontinent	
Commode							
Bedpan/Urinal							

Medications

Drug, Strength, Mode Frequency

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Are patient's living conditions adequate? Y N

Does patient have help at home? Y N

Screening for syphilis by a seriological method

Allergies

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Diagnosis Given	Explained To: Patient <input type="checkbox"/> Family <input type="checkbox"/>	Prognosis	Explained To: Patient <input type="checkbox"/> Family <input type="checkbox"/>
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Services Requested: Nursing Occ. Therapy Speech Therapy Phys. Therapy Social Worker Other
 Patient essentially homebound? Y N

This patient does/does not need twenty-four hour nursing care. This patient is/is not physically and mentally capable of making his/her own way without assistance to a place of safety outside the building.

Physician Signature _____ **Date:** _____