



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

- Assisted Living***
The Village
- Long-Term Care**
- Short-Term Respite Care**

Adult Day Program

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

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

**** Save application and email to LConsiglio@waveny.org****

FOR INTERNAL OFFICE USE ONLY

Dx: _____

Dx: _____

Med. Record #: _____ Room #: _____

Date of Application: _____

FINANCIAL APPROVAL:

CFO Signature: _____ Date: _____