Hospital for Special Care
2150 Corbin Avenue
New Britain, CT 06053
Telephone: (860) 827-4715 Fax: (860) 832-6273
NEUROBEHAVIORAL PROGRAM APPLICATION FOR ADMISSION

NAME:_____ M/F DOB:_____ AGE: _____

MAILING ADDRESS:_____

TELEPHONE: _____

CURRENT LOCATION:_____

REFERRAL

DATE OF BRAIN INJURY: _____ NATURE OF BRAIN INJURY: _____

REASON FOR REFERRAL/BEHAVIORAL PROBLEMS: _____

_____

HAS A NEUROPSYCHOLOGICAL EXAM BEEN COMPLETED? Y / N DATE:_____ FACILITY: _____

(Please attach a copy of the Neuropsychological Exam Report.)

Is the applicant conserved? Yes If YES, is it voluntary or involuntary? (*Please circle and then complete below.*)

CONSERVATOR OF PERSON: _____ TELEPHONE: _____

ADDRESS:_____

CONSERVATOR OF ESTATE:_____ TELEPHONE:_____

ADDRESS: _____

(Please attach copy of conservatorship decree.)

INSURANCE

MEDICARE#:_____ SOCIAL SECURITY#:_____

MEDICAID#:_____

OTHER INSURANCE:_____ POLICY#: _____

HAS APPLICANT APPLIED FOR DISABILITY/SSDI? Yes DATE APPROVED:_____

IS APPLICANT A DMHAS CLIENT? Yes IF YES, CONTACT PERSON:_____

REFERRAL SOURCE

NAME: _____ TELEPHONE: _____

EMAIL: _____ RELATIONSHIP TO APPLICANT: _____