Admission Application

* All information supplied shall remain confidential. Application cannot be processed without this form.

Resident Name: ____________________

Home address: ____________________
____

Are You a U.S. Citizen? □Yes □ No

Phone#: ____________________

Present Location: ____________________

If hospital, date of admit: ____________________

Current living arrangements: ____________________

Location for the past 5 years (list all addresses)
____
____
____
____
____

Date of birth: ____________________

Birthplace: ____________________

Marital Status: ____________________

Religion: ____________________

Former Occupation: ____________________

Community physician: ____________________

Hospital preference: ____________________

Pharmacy preference: ____________________

Funeral preference: ____________________

Prepaid funeral account? □ Yes □ No

Have arrangements been made? □ Yes □ No

Will prior living accommodations be available after placement? □ Yes □ No

Have any HOME CARE services been used in the past? □ Yes □ No Agency? ____________________

How does applicant plan to pay for cost of care? ____________________

Does the applicant have an ADVANCE DIRECTIVE? □ Yes □ No

Have arrangements been made to be an ORGAN DONOR? □ Yes □ No

Emergency Contact

Contact 1

Name: ____________________

Relationship: ____________________

Address: ____________________

Phone # (Home): ____________________

Phone # (Work): ____________________

Contact 2

Name: ____________________

Relationship: ____________________

Address: ____________________

Phone # (Home): ____________________

Phone # (Work): ____________________

Contact 3

Name: ____________________

Relationship: ____________________

Address: ____________________

Phone # (Home): ____________________

Phone # (Work): ____________________

Contact 4

Name: ____________________

Relationship: ____________________

Address: ____________________

Phone # (Home): ____________________

Phone # (Work): ____________________

Type of Stay

□ **REHAB** □ **HOSPICE** □ **RESPITE** □ **LONG TERM CARE** □ **ASSISTED LIVING**

We will need copies of the following:

(copies can be made if desired)

- ► **MEDICAID Card (both sides)**
- ► **MEDICARE D Card (both sides)**
- ► **Insurance Card (both sides)**
- ► **Green Card (both sides if applicable)**
- ► **Living Will**
- ► **Power of Attorney & Conservatorship Documents**

Thank you for taking the time to complete this application. Please tell us how you heard about this facility.
____

Financial Disclosure

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Resident Name: ______________________________
Social Security #: ______________________ Medicare #: ______________________
Medicare D#: ______________________
Medicaid #: ______________________ Pending as of: ______________________
MassHealth#: ______________________ Pending as of: ______________________
DSS Case Worker: ______________________ Phone #: ______________________
Other Medical Insurance: ______________________ Policy ID#: ______________________
Life Insurance Company: ______________________ Surrender Value: $______________________
Does applicant own a partnership-approved long term care insurance policy? ______________________
Other long term care insurance: ______________________ Company: ______________________

Current Monthly Income

Social Security: $______________________ Where is this mailed?______________________
Pension: $______________________ Where is this mailed?______________________
VA Benefits: $______________________ Where is this mailed?______________________
SSI: $______________________ Where is this mailed?______________________
CDs: $______________________ IRAs: $______________________
Annuities: $______________________ Dividends: $______________________
Other Income: $______________________

Does Applicant have a Trust: □ Yes □ No If yes, explain: ______________________

Cash Asset	Bank	Account #	Type	Amount

Current Non Liquid Assets: $______________________

Real Estate

Does the applicant own any property? □ Yes □ No
Type & location: ______________________
Names on deed: ______________________
Estimated value: $______________________ Payable on mortgage: $______________________
Has there been any sale or transfer of property/assets (liquid/non-liquid) within the past 60 months? □ Yes □ No
If yes, please specify amount & to whom: ______________________
Was applicant and/or spouse a member of the US Armed Forces? □ Yes □ No Branch: ______________________
Where has the applicant been within the past 60 days?: ______________________
____

If applicant is unable to handle their financial affairs, to whom can outstanding bills be sent for payment?
Name: ______________________ Phone: ______________________
Address: ______________________
Relationship to applicant: ______________________

______________________ ______________________
Signature of Person Completing Application Date

Medical Data

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Resident Name: ____
Current Physician: ____________________ Will physician be following? □ Yes □ No
Current Diagnosis: ____
Past Medical History: ____
Medications: ____

Nursing Needs

Indicate all that apply

Ambulation
- □ Independent
- □ With Assist
- □ Walker
- □ Cane
- □ Wheelchair
- □ Bedbound
- □ Transfers
  - □ Ind.
  - □ Assist of
- □ 1 □2

Continence
- □ Continent
- □ Incontinent
  - □ Bowel
  - □ Bladder
- □ Foley Catheter
- □ Texas Catheter
- □ Sup. Pub. Cath.
  - □ Ostomy (type) ____________________

Feeding
- □ Independent
- □ With Assist
  - □ Total Assist
  - □ Feeding Tube
    - □ NG Tube
    - □ Gastric
    - □ J-tube
  - □ Rate
  - □ Solution
- □ Special Diet ____________________

Bathing
- □ Independent
- □ With Assist
- □ Total Care

Dressing
- □ Independent
- □ With Assist
- □ Total Care

Adaptive Equipment: (type) ____
____

Mental Status
- □ Alert
- □ Understands
- □ Forgetful
- □ Confused
- □ Non Responsive
- □ Oriented
- □ Disoriented

Behavior
- □ Cooperative
- □ Depressed
- □ Withdrawn
- □ Belligerent
- □ Noisy
- □ Needs Restraints
- □Wanders
- □ Combative

Miscellaneous
- Weight ____________________
- Height ____________________
- □ Hearing Impaired ____________________
- □ Speech Impaired ____________________
- □ Vision Impaired ____________________
- □ Dentures ____________________
- □ Allergies ____________________
- □ Skin:
  - □ Intact ____________________
  - □ Reddened ____________________
  - □ Open Area
  - □ Size ____________________

Therapies Received: ____________________
Therapies Needed: □ P.T. □ O.T. □ Speech

Treatments: ____
____

Other Pertinent Medical Information: ____
____
____