



CONFIDENTIAL ADMISSIONS APPLICATION

Applications must be filled out in entirety for processing

- | | | |
|--|---|--|
| <input type="checkbox"/> Bay Path, Duxbury | <input type="checkbox"/> Hancock Park, Quincy | <input type="checkbox"/> Brighton House, Brighton |
| <input type="checkbox"/> John Scott House, Braintree | <input type="checkbox"/> Harbor House, Hingham | <input type="checkbox"/> The Bostonian, Dorchester |
| <input type="checkbox"/> Ledgewood, Beverly | <input type="checkbox"/> Seacoast, Gloucester | |
| <input type="checkbox"/> Craneville Place, Dalton | <input type="checkbox"/> Springside, Pittsfield | |

TYPE OF STAY:

- SHORT-TERM REHABILITATION LONG-TERM CARE HOSPICE RESPITE

Resident Name: _____ Age: _____ Date of Birth: _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

► Social Security #: _____ ► Medicare #: _____

► Medicaid #: _____ ► HMO Insurance: _____

Additional Medical Insurance/Long-term Insurance: _____

Policy #: _____ Group #: _____

Has the Applicant been hospitalized or in a nursing facility in the past 3 months? YES NO

Have any HOME CARE services been used in the past? YES NO Agency: _____

EMERGENCY CONTACT:

► **Primary:** Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

► **Secondary:** Name: _____ Relationship: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell: _____

We will need copies of the following:

- MEDICAID Card
- MEDICARE D Card
- Insurance Card
- MOLST
- Power of Attorney or Conservatorship Documents
- Healthcare Proxy

Has the Applicant had a Long-Term Care Screening to determine nursing home eligibility? YES NO

If so, where? _____ Date: _____

MEDICAL DATA:

Current Physician: _____ Will Physician be following? YES NO

Current Diagnosis: _____

Current Medications: _____

Past Medical History: _____

NURSING NEEDS: *INDICATE ALL THAT APPLY

AMBULATION:

Independent With Assist Walker Cane Wheelchair Bed bound

▶ Transfers: Independent Assist of: 1 or 2 (**Please circle one*)

In what areas does the Applicant require assistance?

Bathing Dressing Grooming Prosthetic Devices Hearing Aid
 Catheter Oxygen Dentures Special Skin Care

Is the Applicant incontinent? YES NO *If yes, check which apply:* Bowel Bladder

MENTAL STATUS:

Alert Understands Forgetful Confused Oriented Disoriented
 Cooperative Depressed Withdrawn Non-Cooperative Well-Adjusted
 Wanders Combative Non-Responsive

Please provide any additional comments:

▶ Signature: _____

▶ Print Name: _____

▶ Date: _____

Please mail, fax, OR return application in person, no emails accepted.

- *Fax Number for Duxbury, Quincy, Braintree, & Hingham locations: 781-394-8568*
- *Fax Number for Brighton & Dorchester locations: 781-394-5515*
- *Fax Number for Beverly & Gloucester locations: 781-394-2552*
- *Fax Number for Dalton & Pittsfield locations: 877-608-4601*

Thank you for taking the time to complete this application.