CONFIDENTIAL ADMISSIONS APPLICATION

Application cannot be processed without this form.

PLEASE SELECT A FACILITY OF INTEREST: ▶ CHECK ONE OR MORE

☐ Bay Path, Duxbury
☐ John Scott House, Braintree
☐ Ledgewood, Beverly
☐ Craneville Place, Dalton
☐ Hancock Park, Quincy
☐ Harbor House, Hingham
☐ Seacoast, Gloucester
☐ Springside, Pittsfield
☐ Brighton House, Brighton
☐ The Bostonian, Dorchester

TYPE OF STAY:

☐ SHORT-TERM REHABILITATION ☐ LONG-TERM CARE ☐ HOSPICE ☐ RESPITE

Resident Name: ____ Age: _____ Date of Birth: ___________
Home Address: ____
City: _____________________________ State: ________________ Zip Code: ___________________
Marital Status (check one): ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

▶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
- Living Will
- Power of Attorney & 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 ALLTHAT 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,: 781-394-8568
Fax Number for Brighton & Dorchester: 781-394-5515
Fax Number for Beverly & Gloucester: 781-394-2552
Fax Number for Dalton & Pittsfield: 877-608-4601

Thank you for taking the time to complete this application.