



97 Bethany Road, Framingham, MA 01702-7237
(508) 872-6750 · Fax: (508) 875-5425
www.bethanyhealthcare.org

We have many applicants at various stages in the pre-admission process. Once all the documentation is completed each applicant will be considered for admission when an appropriate placement is available, we will contact you at that time.

APPLICATION

(please complete all 4 pages)

Date _____

Name _____

Address _____

Telephone #(s) _____ Email: _____

Birthdate _____ Age _____ () Male () Female

Marital Status () Married () Single () Widowed () Divorced

Religion _____ Occupation _____ Education _____ Primary Language _____

Primary Care Physician

Name _____

Address _____

Phone #'s _____

Responsible Party

Name _____

Address _____

Phone #'s _____

Relationship _____

Has applicant been screened for Long Term Care eligibility if Medicaid?
() Yes () No

Agency Name and Phone # _____

Medical Information

Does applicant have a diagnosis of depression or mental illness?

() Yes () No

Onset of diagnosis - date: _____

Principal Diagnosis _____

Other Diagnosis including Past Medical History _____

Surgeries

Ambulation

- () Independent
- () w/assist
- () Walker
- () Cane
- () Wheelchair
- () Bed bound
- () Transfers
- () Independent
- () Assist

Continance

- Bladder
- () Continent
- () Incontinent
- Bowel
- () Continent
- () Incontinent
- () Catheter
- () Ostomy

Feeding

- () Independent
- () Set-Up
- () Assist
- () Must be Fed
- () Special Diet

Bathing

- () Independent
- () Supervision
- () w/assist
- () Total Care

Dressing

- () Independent
- () w/Assist
- () Total Care

Mental Status

- () Verbal
- () Non-responsive
- () Alert
- () Oriented
- () Confused
- () Forgetful

Behavior

- () Cooperative
- () Depressed Mood
- () Withdrawn
- () Agitated
- () Noisy
- () Wanders

Other

- Height _____
- Weight _____
- Hearing Aids ()
- Eye Glasses ()
- Dentures ()
- Allergies ()

(please check off those that apply)

Medications

Dosage

Frequency

Other Specialty Doctors Visited

FINANCIAL INFORMATION SHEET

This information is essential in order to assist the resident in forecasting if and when Medicaid Certification will be needed.

Full Name _____ Social Security Number _____

Method of Payment

Private Pay (funds available for monthly room charge) _____

Medicare # _____ Part A Effective Date _____
Part B Effective Date _____

Medicare Part D - Prescription Coverage
Name of Carrier _____

MedEx # _____

Gold Core Bronze

Medicaid # _____
Effective date _____

Medicaid under Commission for the Blind # _____

Evercare # _____

Other Medical Insurance Companies # _____
Name of Carrier _____

Are you a Veteran? Yes No

Tricare Insurance # _____

It is strongly recommended that provisions be made to have Pension and/or Social Security checks be sent directly to the facility in order to alleviate any financial problems.

Are Pension/Social Security Checks to come directly to Bethany Health Care Center?

Yes No (If no please indicate below person(s) to be billed)

Name _____

Telephone Number(s) _____

Address _____

If Medicaid application is pending, include name and phone number of caseworker and estimated time for approval.

Name _____ Tel Number _____

Applicants Check List (include copies of the following if applicable)

Medicaid - Medicare - Prescription and Medical Cards

Health Care Proxy Guardianship Papers Power of Attorney

Letter of Eligibility for Long Term Care (if Medicaid)

Prepaid Funeral Home Plan Discussed Resuscitation Directives

Financial Information

A. Source of Income
Recipients Name
Monthly Amount Social Security
Retirement/Pension
V.A. Pension
Rental Income
Annuities/Investments
Other (specify)

B. Assets
Table with 3 columns: Name of Bank, Type of Account, Value

Do you own: Stocks Bonds CD's Mutual Funds
Approximate Value
Insurance Company
Policy Number
Face Value
Have you created a trust (since 1990) or transferred assets (in the last 60 months)? Yes No Explain

(copy of Trust Instrument requested)
Do you own a home? Yes No Live Alone? Yes No
Do you have Long Term Care Insurance? Yes No
Company
Policy Number
Address
Telephone Number

Burial Arrangements

Funeral Home
Address Tel

Emergency Notification

Table with 4 columns: Name, Complete Address, Relationship, Phone #'s

*I hereby state that, to the best of my knowledge and belief, the above stated information is true, correct and complete. All of the information will be kept confidential by Bethany Health Care Center, and will not be released without my written permission.

Signature of Applicant Date
Signature of Responsible Party Date