Bethany
HEALTH CARE CENTER
A Sponsored Ministry of the Sisters of St. Joseph of Boston
97 Bethany Road | Framingham, MA 01702-7237 | (508) 872-6750 | Fax: (508) 875-5425

APPLICATION FOR ADMISSION

(Please complete all pages)

Applicant Name: _____ Date: _____

Address: _____

_____

Telephone Number(s): _____ Email:_____

Birthdate: _____ Age: _____ ( ) Male ( ) Female

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

Religion: _____ Education Level: _____ Primary Language: _____

Primary Care Physician

Name: _____

Address: _____

Phone Number(s): _____

Responsible Party

Name: _____

Address: _____

*Phone Number(s):*_____

Relationship:_____

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

Agency Name and Phone Number: _____

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.

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: _____

_____

Please check all that apply

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

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

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

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

Bathing
( ) Independent
( ) Supervision
( ) 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( ) Withdrawn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
( ) Eyeglasses
( ) Dentures
( ) Allergies _____

Medications *(attach additional sheet if needed)*	***Dosage***	***Frequency***
_____	_____	_____
_____	_____	_____

Other Specialty Doctors Visited

_____

_____

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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 #_____

( ) UnitedHealthcare #_____

( ) 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 the 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 _____ Telephone Number _____

Applicant 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

	Recipient's Name	Monthly Amount
Social Security	_____	_____
Retirement/Pension	_____	_____
V.A. Pension	_____	_____
Rental Income	_____	_____
Annuities/Investments	_____	_____
Other (specify)	_____	_____

B. Assets

Name of Bank	Type of Account	Value
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you own? Stocks _____ Bonds _____ CDs _____ 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

Explanation _____ (copy of Trust Instrument requested)

Do you own a home? ( ) Yes ( ) No Do you live alone? ( ) Yes ( ) No

Do you have Long Term Care Insurance? ( ) Yes ( ) No

Company _____ Policy Number _____

Address _____ Telephone Number _____

BURIAL ARRANGEMENTS

Funeral Home _____

Address_____ Telephone _____

EMERGENCY NOTIFICATION

Name	Complete Address	Relationship	Phone Number(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 _____

Rev. 03.19