Bethany HEALTH CARE CENTER

A Sponsored Ministry of the Sisters of St. Joseph of Boston

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 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: _____ Primary Language: _____

Primary Care Physician

Name: _____

Address: _____

Phone Number(s): _____

Responsible Party

Name: _____

Address: _____

Email Address: _____ *Phone Number(s):* _____

Relationship: _____

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

Agency Name and Phone Number: _____

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

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

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

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

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( ) Withdrawn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
( ) Eye Glasses
( ) Dentures
( ) Allergies _____

(please check off those that apply)

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 _____ Number: _____

( ) MedEx #_____ ( ) Gold ( ) Core ( ) Bronze

( ) Medicaid # _____ Effective date: _____

( ) Medicaid under Commission for the Blind #: _____

( ) United Health Care#_____

( ) Other Medical Insurance Companies #: _____

Name of Carrier _____ Number: _____

( ) 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: _____

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

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: _____ 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:** _____