



A MINISTRY OF THE SISTERS OF CHARITY (HALIFAX)

Return Completed Application to:
Elizabeth Seton Residence
Attention: Admissions Office
125 Oakland Street
Wellesley Hills, MA 02481-5338

ELIZABETH SETON RESIDENCE CONFIDENTIAL APPLICATION

Date Application Submitted: _____ Date Seeking Placement: _____

Contact Person: _____ Relationship: _____

Contact's Phone: _____ E-Mail: _____

Name of Applicant: _____ Applicant's Phone: _____

Date of Birth: _____ Age: _____ Sex: Male: _____ Female: _____

Applicant's Current Address: _____

Social Security Number: _____

Marital Status: Never Married: _____ Married: _____ Widowed: _____ Divorced: _____

Spouse Name: _____

Applicant's Place of Birth: _____

Primary Language: _____

Lifetime Occupation: _____

Religion: _____ Clergy Contact: _____

Church/Temple: _____ Funeral Home: _____

Primary Care Physician: _____

Address: _____ Telephone: _____

Preferred Hospital: _____

Consultants/Specialists who regularly see the applicant:

Name: _____ Specialty: _____

Name: _____ Specialty: _____

WHAT IS PROMPTING YOU TO SEEK NURSING HOME ADMISSION AT THIS TIME?

PRESENT MEDICAL/FUNCTIONAL STATUS OF APPLICANT:

***Please be specific with all information to assure appropriate consideration and placement.**

APPLIANCES / ASSISTIVE DEVICES CURRENTLY USED: (please check all that apply)				
Dentures _____	Upper _____	Lower _____	Glasses _____	Contacts _____
Magnifying glass _____		Artificial eye _____ Which one? Left ___ Right ___		
Walker ___	Rolling Walker ___	Cane ___	Wheelchair _____	Brace ___ (type): _____
Hearing Aid: YES ___ NO ___		Right _____	Left _____	
OTHER:				
ASSISTANCE REQUIRED WITH ACTIVITIES OF DAILY LIVING: (please check as appropriate)				
	Extensive	Some	Little/None	COMMENTS:
Dressing/Grooming				
Bathing				
Ambulation/Mobility				
Medications				
Eating				
Toileting				
Is Applicant Diabetic:	YES: _____	NO: _____		
Is Applicant Continent:	Bladder: YES ___ NO ___	Bowel: YES ___ NO ___		
Anything else that would be helpful for us to know:				

<p>___ Please attach a recent primary care physician's medical summary or recent note.</p> <p>___ If the applicant is currently in a skilled nursing and rehabilitation facility, please request a copy of the most recent "MDS Documentation" from the facility and include with this application.</p>				

MENTAL STATUS/BEHAVIOR OF APPLICANT

Please check all that apply regarding present mood state and behavior:

<input type="checkbox"/> Alert and Oriented	<input type="checkbox"/> Poor Short Term Memory	<input type="checkbox"/> Poor Long Term Memory
<input type="checkbox"/> Depressed	<input type="checkbox"/> Anxious	<input type="checkbox"/> Agitated
<input type="checkbox"/> Wanders	<input type="checkbox"/> Aggressive	<input type="checkbox"/> Cooperative with Care
<input type="checkbox"/> Follows Directions	<input type="checkbox"/> Social	<input type="checkbox"/> Enjoys Group Activity
<input type="checkbox"/> Agreeable to Admission		

The following information is required for PRE-ADMISSION SCREENING under the OBRA Regulations. All information is kept CONFIDENTIAL.

Does applicant have a history of mental illness, anxiety, or depression, which required hospitalization, psychiatric support service or use of psychotropic medications and/or ECT?

YES NO

If YES, please describe history, present status and list of current meds including dosage amounts and length of use:

APPLICANT INSURANCE INFORMATION

Medicare #: _____

Medex #: _____

HMO #: _____

Carrier: _____

Medicare Part D? YES NO

Name of Part D Provider:

Other Prescription Coverage? _____

Long Term Care Insurance #: _____

Mass Health/Medicaid #: _____

Has Resident been screened for Long Term Eligibility by Elder Services? YES NO

(Required for Mass Health applicants and recipients prior to admission)

Contact: (508) 756-1545 for Screening Information.

****PLEASE include photocopy of all health care cards to ensure accurate billing****

Has applicant been hospitalized within the last 60 days? **YES** ____ **NO** ____
If answer is **YES**, please provide the following information:

Date of Most Recent Hospitalization: _____ Name of Hospital: _____

Admitting Diagnosis: _____

Was applicant admitted to a nursing home / rehab facility prior to this application: **YES** ____ **NO** ____
If **YES**, please answer the following specifically to ensure proper Medicare Billing.

Name of Facility: _____ Dates of Admission: _____

Payment Source for above admission:
Medicare _____ Medicaid _____ Private Insurance _____ Private Pay _____

RESPONSIBILITY PARTY INFORMATION FOR BILLING / HEALTHCARE DECISIONS

Health Care Proxy:

Power of Attorney:

Name : _____

Name: _____

Address: _____

Address: _____

City/State: _____ ZIP: _____

City/State: _____ ZIP: _____

Telephone Numbers: (H) _____

Telephone Numbers: (H) _____

(W) _____ Cell _____

(W) _____ Cell: _____

E-mail _____

E-mail _____

Next of Kin:

Additional Emergency Contact Names:

Name: _____

Name: _____

Address: _____

Relationship: _____

City/State: _____ ZIP: _____

City/State: _____ ZIP: _____

Phone Numbers: (H) _____

Phone Numbers: (H) _____

(W) _____ Cell _____

(W) _____ Cell: _____

E-mail _____

E-mail _____

****Photocopies of Health Care Proxy, Power of Attorney and Guardianship must be provided****

FINANCIAL INFORMATION

Sources of Monthly Income:

Social Security \$ _____

Retirement Pension \$ _____

Annuities/Investments \$ _____

Other: \$ _____

Other: \$ _____

Real Estate Assets:

Applicant's Home/Residence Tax Assessed Value \$ _____

Property owned jointly or individually? _____

Does applicant own additional property? YES ___ NO ___ VALUE _____

Please list other assets and investments including stocks, bonds, Mutual Funds, IRA's, Life Insurance, etc., including present value.

Name of Bank	Type of Account	Value

**ALL INFORMATION MUST BE COMPLETED
PRIOR TO THIS APPLICATION BEING
CONSIDERED FOR ADMISSION**

I hereby state to the best of my knowledge that all above information is accurate, complete and true.

I understand that if any information has been falsely represented, this will be sufficient cause for voiding this application for admission.

I understand and agree that this application is neither a contract, nor a reservation for residence.

I understand that I may contact the admissions office to provide any updates or changes to the above information as needed by calling 781-997-1102.

Signature of Applicant (if able): _____

Signature of Responsible Person: _____

Today's Date: _____

Application Packet Checklist: Please include ALL DOCUMENTS for consideration.

- Completed Application – All Pages
- Photocopy of all Health Care Cards
- Photocopy of:
 - Healthcare Proxy
 - Power of Attorney
 - Guardianship (if applicable)
- Current Medication List, Including Dosages
- Primary Care Physician's Note / Medical Summary
- Copy of most recent "MDS" Document from referring facility (if coming from another Skilled Nursing Facility)

QUESTIONS? Please Call Admissions at 781-997-1102. Thank you!

Date Received by Facility: _____ *Reviewed by Facility Representative:* _____

PLEASE ATTACH A LIST OF CURRENT MEDICATIONS or LIST BELOW

MEDICATIONS

NAME: _____ DATE: _____

Any ALLERGIES to MEDICATIONS? No ___ Yes ___ FOOD? No ___ Yes ___ Other? No ___ Yes ___

Specify: _____

Type of REACTION? _____

NAME OF MEDICATION	DOSE	REASON

NOTES:
