COUNTRYSIDE HEALTH CARE OF MILFORD
APPLICATION FOR ADMISSION
* PERSONAL AND CONFIDENTIAL *

1. RESIDENT APPLYING FOR:

____ Traditional Long Term Care ____ Memory Care Long Term Care ____ Uncertain

2. GENERAL INFORMATION CONCERNING PROSPECTIVE RESIDENT:

Resident's Name ____

Birthdate ____________________ Place of birth (county/state) ______________________________

Home Address ____

City ________________________ County ________________ State & Zip Code ____________

Marital Status ______________ Previous Occupation ____________________________________

Religion __________________________ Church ____

Military Service ____

Father's Name ________________________ Mother's Maiden Name ________________________

Referred to this Facility by ____

Resident is now at:

____ Home ____ *Hospital ____*Nursing Home ____*Assisted Living ____ *Other

*Facility Information: Name ____

Admission Date ____

Has the Resident ever been in another nursing center? ____ Yes ____ No

If yes, Facility Name and Dates there ____

Is the Resident aware of the placement decision? ____ Yes ____ No

Personal Physician's Name ____

Address ____

Telephone ____

3. CONTACT PERSON:

Name ____ Relationship to Resident ______________

Mailing Address ____

City ____ State & Zip Code __________________

Telephone (home) ______________________________ (cell) ______________________________

Email address ____

Preferred method of contact ____

4. POWER OF ATTORNEY:

Has anyone been appointed Power of Attorney or Guardian? ____ Yes ____ No

If so, who? ____ Relationship ____________________

5. PERSON RESPONSIBLE FOR BILL PAYMENTS:

Name ____ Relationship ____________________

Mailing Address ____

Phone # ______________________ Email Address ____

6. ADDITIONAL CONTACTS:

Name ____ Relationship ____________________

Home Address____

City ____ State/Zip Code _____________________

Telephone (home) ________________________________ (cell) _____________________________

Email Address____

Name ____ Relationship ____________________

Home Address____

City ____ State/Zip Code _____________________

Telephone (home) ________________________________ (cell) _____________________________

Email Address____

7. FINANCIAL INFORMATION CONCERNING RESIDENT:

All questions must be answered as completely and accurately as possible.

Social Security # ___________________________ Medicare # ______________________________

Medicare Part A? ____ Yes ____ No

Medicare Part B? ____ Yes ____ No

Medicare Part D? ____ Yes ____ No

Medex/Medigap # ____

Medicare supplemental insurance ____

Prescription Card _______________________ Policy # ____________________________________

Long Term Care Insurance __________________________ Policy # _________________________

Other Insurance ___________________________________ Policy # _________________________

8. MEDICAID/MASSHEALTH:

Does Resident have Medicaid/MassHealth?

____ Yes Medicaid/MassHealth # ____

____ No If no, has Resident applied, or will Resident shortly be applying for Medicaid/MassHealth? ____ No

____ Yes Application date ________________________

If yes, Attorney or service company completing the Medicaid/MassHealth application:

Name ____

Phone # ____

9. WHAT IS RESIDENT'S PAYER SOURCE FOR LONG-TERM CARE?

____ Private Pay ____ Medicaid/MassHealth ____ Long-term care insurance

____ Other ____

10. MONTHLY INCOME:

____ Social Security Monthly Amount $ ____________________________

____ Civil Service Retirement Monthly Amount $ ____________________________

____ V.A. Pension Monthly Amount $ ____________________________

____ Military Retirement Monthly Amount $ ____________________________

____ Railroad Retirement Monthly Amount $ ____________________________

____ Rental Income Monthly Amount $ ____________________________

____ *Other Monthly Amount $ ____________________________

*(specify) ____

11. CASH ASSETS IN BANKS, CREDIT UNIONS, SAVINGS AND FINANCIAL INSTITUTIONS:

Institution Name ___________________________________ Location ___________________________

Type of Account ___________________________________ Balance in Account $ ________________

Names Listed on Account ____

Institution Name ___________________________________ Location ___________________________

Type of Account ___________________________________ Balance in Account $ ________________

Names Listed on Account ____

Institution Name ___________________________________ Location ___________________________

Type of Account ___________________________________ Balance in Account $ ________________

Names Listed on Account ____

12. LIFE INSURANCE CASH VALUE:

Does the Resident have life insurance policies with cash value? ____ *Yes ____ No

*Company Name ____

*Approximate cash value $ ______________________ Annuities $ ____________________

13. REAL ESTATE ASSETS:

Does the Resident own a home? ____ *Yes ____ No *Approximate value $ ______________

Is Property owned jointly? ____ Yes ____ No

If yes, Names of co-owners ____

Does Resident own any additional property? ____ *Yes ____ No

*Approximate value $ ________________

14. FUNERAL ARRANGEMENTS:

Has the Resident made pre-paid funeral arrangements? ____ Yes ____ No

Funeral Home preference:

Name ______________________________________ Phone # ______________________

15. OTHER ASSETS/INVESTMENTS (stocks, bonds, IRAs):

Company Name ______________________________ Approximate value $ ______________

Company Name ______________________________ Approximate value $ ______________

Company Name ______________________________ Approximate value $ ______________

Company Name ______________________________ Approximate value $ ______________

I hereby certify that to the best of my knowledge and belief, the above stated information is true, correct and complete. I understand any information that has been falsely represented will cause my application to be incomplete and result in a delay for admission. All of the information will be kept confidential by the facility.

____ ________________________

Signature of Resident Date

____ ________________________

Signature of Person filling out application Date

____

Printed Name of Person filling out application