RE: _____

DATE REC'D: _____

LTC: _____
(for office use only)

D'YOUVILLE LIFE & WELLNESS COMMUNITY

D'Youville Senior Care

APPLICATION FOR ADMISSION

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Patient Name: _____ Date: _____

Address: _____ Zip: _____ Phone: _____

Current Location: Home Hospital Other _____ Date of Admission: _____

If Hospital, Case Manager's Name: _____

Inquiry made by: _____ Phone: _____

Age: _____ Sex: _____M _____F Birthdate: _____ Religion: _____

Marital Status: M S W D Parish/Congregation _____

Former Occupation: _____ How did you hear about us? _____

Are you seeking: Long Term Care Short Term Care

Contact (1) Name: _____ Relationship: _____

Address: _____ Zip _____

Home Phone: _____ Work Phone: _____

Contact (2) Name: _____ Relationship: _____

Address: _____ Zip _____

Home Phone: _____ Work Phone: _____

Name of Health Care Proxy Agent: _____ Power of Attorney _____

Conservator _____ Guardian _____

Method of Payment: Private ____ Medicare ____ Medicaid ____ Other _____

Social Security # _____ Other _____

Medicare # _____ Part A ___Yes ___No Part B ___Yes ___ No

Other Insurance ___Yes ___No Company: _____ Policy #: _____

Phone # _____ Type of Coverage _____

Patient's Diagnosis / Medical Problems: _____

_____

_____

Please list patient's medications: _____

_____

_____

Patient's Primary Physician: _____ Phone: _____

PATIENT CARE INFORMATION:

Does patient feed self? _____

Does patient walk? _____ Independent _____ Assist _____

Walker _____ Cane _____ Not at all _____

Does patient need assist with the following: Bathing _____

Dressing _____ Toileting _____ Transfers _____

Is patient continent? Bladder _____ Bowel _____

Describe patient's skin condition

_____

Any open areas on skin: _____

Does patient have any communicable diseases? _____

_____

Does patient have any diet restrictions or special preferences? _____

_____

Describe patient's vision and hearing: _____

Describe patient's speech: _____

Does patient have any sleep disturbance? _____

Does patient have any problem with pain? _____

Is patient alert: _____ Oriented to person _____ Place _____ Time _____

Is patient aware of request for placement: _____

Behavior

Withdrawn _____ Noisy _____ Cooperative _____ Anxious _____

Agitated _____ Strike out at others: _____ Depressed _____

Does patient have any history of emotional/mental disorders? _____

_____

_____

Describe patient's daily routine:

_____

_____

NAME OF APPLICANT SEEKING ADMISSION _____

FINANCIAL RESOURCES:

TOTAL PENSION AMOUNT (PER MONTH) $ _____

SOCIAL SECURITY AMOUNT (PER MONTH) $_____

OTHER INCOME (PER MONTH) $_____

REAL ESTATE: DESCRIPTION AND ADDRESS OF ANY REAL ESTATE OWNED IN THE LAST 5 YEARS:

_____

APPROXIMATE VALUE IF CURRENTLY OWNED:_____

MORTGAGE BALANCE:_____

NAME OF PERSON(S) ON OWNERSHIP PAPERS:

_____

IS THERE RENTAL INCOME? _____ MONTHLY RENT_____

PLEASE LIST BANK/INVESTMENT/BROKERAGE ACCOUNTS:

1._____ BALANCE $_____

2._____ BALANCE $_____

3._____ BALANCE $_____

4._____ BALANCE $_____

IN THE PAST 60 MONTHS HAS THERE BEEN ANY TRANSFER, CHANGE OF OWNERSHIP OF ANY REAL ESTATE, INCLUDING CREATING A LIFE ESTATE, EVEN IF THE LIFE ESTATE WAS PURCHASED IN ANOTHER PERSON'S RESIDENCE?

YES_____ NO_____

IF YOU PURCHASED A LIFE ESTATE IN ANOTHER PERSON'S HOME, DID YOU LIVE IN THE HOME FOR AT LEAST ONE YEAR AFTER YOU PURCHASED THE LIFE ESTATE?

YES____NO____

DID YOU, YOUR SPOUSE, OR SOMEONE ON YOUR BEHALF ADD ANOTHER NAME TO THE DEED OF ANY PROPERTY YOU OWN? YES_____NO_____

DID YOU, YOUR SPOUSE, OR SOMEONE ON YOUR BEHALF PURCHASE OR IN ANY WAY CHANGE AN ANNUITY? YES_____NO_____

FINANCIALLY RESPONSIBLE PERSON:

NAME:_____

ADDRESS:_____

HOME PHONE:_____CELL PHONE:_____

RELATIONSHIP TO APPLICANT_____

*PLEASE PROVIDE A COPY OF POWER OF ATTORNEY OR GUARDIANSHIP APPOINTMENT IF APPLICABLE

NAME AND ADDRESS OF ATTORNEY HANDLING AFFAIRS IF APPLICABLE:

_____

PLEASE DISCLOSE ANY ADMISSIONS/CONFINEMENTS TO ANY OTHER HEALTHCARE FACILITIES IN THE PAST 12 MONTHS:

FACILITY NAME:_____ DATES:_____

FACILITY NAME:_____ DATES:_____

*INSURANCE INFORMATION INCLUDING COPIES OF ALL INSURANCE CARDS MUST BE PROVIDED TO D'YOUVILLE PRIOR TO ADMISSION.

*PLEASE PROVIDE SUPPORT FOR THE FINANCIAL RESOURCES LISTED.
PLEASE RETURN COMPLETED FORM WITH VERIFICATIONS TO:

D'YOUVILLE SENIOR CARE
981 VARNUM AVENUE
LOWELL, MA 01854
978-569-1000; FAX: 978-569-1085

SIGNATURE_____ RELATIONSHIP_____

DATE_____

D'YOUVILLE SENIOR CARE DOES NOT DISCRIMINATE ON THE BASIS OF RACE, COLOR, NATIONAL ORIGINS, HANDICAP OR AGE IN OUR ADMISSION POLICY. THIS IS IN ACCORDANCE WITH LAW AND REGULATIONS:

TITLE VI OF THE CIVIL RIGHT ACT 1984 45 CFR PART 80
SECTION 504 OF THE REHAB ACT 1973 45 CFT PART 84
AGE DISCRIMINATION ACT 1975 45 CFR PART 91