



D'YOUVILLE LIFE & WELLNESS COMMUNITY

## D'Youville Senior Care

Thank you for your interest in D'Youville Senior Care. Enclosed you will find an Application for Admission that can be filled out and returned to the Admissions Department. Along with the completed application, Please provide the following documents:

1. Completed Applications
2. Copy of a Health Care Proxys
3. Copy of Durable power of attorney (If Applicable)
4. Copy of Covid Vaccination Card (If Applicable)
5. Copy of a long term care insurance policy ( if applicable)
6. Copy of front and back of insurance cards
7. Copy of most recent Bank Statements and monthly income
8. Copy of 401K, CD's, stocks etc. if applicable

The application will be placed on file for consideration when an appropriate long term bed or beds become available.

If you have any questions or need additional information please do not hesitate to call.

Sincerely,

Admissions Department  
D'Youville Life and Wellness Community  
981 Varnum Avenue  
Lowell, MA 01854  
Tel (978)-569-1000 x2063 Fax (978)- 349-2062

RE: \_\_\_\_\_

DATE REC'D: \_\_\_\_\_

LTC: \_\_\_\_\_  
(for office use only)



# D'Youville

LIFE *&* WELLNESS COMMUNITY

## D'Youville Senior Care

### APPLICATION FOR ADMISSION

**APPLICATION FOR ADMISSION**  
**D'Youville Senior Care**

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: \_\_\_\_\_ Email: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Contact (2) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone: \_\_\_\_\_ Email: \_\_\_\_\_ 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: \_\_\_\_\_

TELEPHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

RELATIONSHIP TO APPLICANT \_\_\_\_\_

\*PLEASE PROVIDE A COPY OF POWER OF ATTORNEY, GUARDIANSHIP APPOINTMENT, AND HEALTH CARE PROXY 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: \_\_\_\_\_

**\* PLEASE PROVIDE COPIES OF INSURANCE CARDS AND SUPPORT FOR THE FINANCIAL RESOURCES LISTED. COMPLETED APPLICATIONS MUST INCLUDE POWER OF ATTORNEY, GUARDIANSHIP APPOINTMENT AND/OR HEALTH CARE PROXY IF APPLICABLE. PLEASE SEND TO:**

D'YOUVILLE SENIOR CARE  
981 VARNUM AVENUE  
LOWELL, MA 01854  
ATTN: ADMISSIONS  
978-569-1000; FAX: 978-349-2062

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 9