D'Youville
LIFE & WELLNESS COMMUNITY

www.dyouville.org
@DYouvilleLowell

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 Proxy
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

D'Youville
LIFE & WELLNESS COMMUNITY

D'Youville Senior Care

FOR OFFICE USE ONLY	
RE:	
DATE REC'D:	
LTC:	

APPLICATION FOR ADMISSION

PATIENT DETAILS

Name:

Date:

Address:

City:

State: Zip:

Phone:

Current location: ☐ Home ☐ Hospital ☐ Other

Sex: ☐ Male ☐ Female Age:

Date of birth:

Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Religion:

Parish/congregation:

Former occupation:

You are seeking: ☐ Long-term care ☐ Short-term care

How did you hear about us?

Inquiry made by:

Relationship to patient:

Phone:

Primary Care Physician's name (if hospital)

Phone:

Fax:

CONTACT ONE

Name:

Relationship:

Address:

City:

State: Zip:

Mobile phone:

Home phone:

Work phone:

Email:

CONTACT TWO

Name:

Relationship:

Address:

City:

State: Zip:

Mobile phone:

Home phone:

Work phone:

Email:

LEGAL, FINANCES AND INSURANCE

Name of health care proxy agent (where applicable):

Guardian:

Conservator:

Power of Attorney:

Method of payment: ☐ Private ☐ Medicare ☐ Medicaid ☐ Other

Social security number:

Other insurance: ☐ Yes (enter company below) ☐ No

Medicare number:

Policy number:

Part A: ☐ Yes ☐ No Part B: ☐ Yes ☐ No

Phone:

Type of coverage:

MEDICAL INFORMATION

Patient's diagnosis/medical problems:

Patient's medications:

Patient's primary physician:

Phone:

PATIENT CARE INFORMATION

Does the patient feed self?

☐ Yes ☐ No

Does the patient need assistance with the following?

☐ Bathing ☐ Dressing
☐ Toileting ☐ Transfers

Does the patient walk?

☐ Independently ☐ With physical assistance
☐ With a walker ☐ Using a cane
☐ Not at all

Is the patient continent?

Bladder: ☐ Yes ☐ No Bowel: ☐ Yes ☐ No

PATIENT CARE INFORMATION CONTINUED

Describe the patient's skin condition:

Open areas on the skin: ☐ Yes (describe below) ☐ No

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?

☐ Yes ☐ No

Is patient orientated to person?

☐ Yes ☐ No

Is patient orientated to place?

☐ Yes ☐ No

Is patient orientated to time?

☐ Yes ☐ No

Is patient aware of request for placement?

☐ Yes ☐ No

Do any of the following describe patient's behavior? (Check all that apply)

☐ Withdrawn
☐ Noisy
☐ Cooperative
☐ Anxious
☐ Agitated
☐ Strikes out at others
☐ Depressed

Does patient have any history of emotional/ mental disorders?

Describe patient's daily routine:

APPLICANT

Name of applicant seeking admission

FINANCIAL RESOURCES

Total pension amount (per month)

$

Social Security amount (per month)

$

Other income (per month)

$

Description and address of any real estate owned in the last 5 years

Approximate value if currently owned

$

Mortgage balance

$

Name(s) of person(s) on ownership papers

Is there rental income ☐ Yes ☐ No

Monthly rent if YES

$

Please list bank/investment/brokerage accounts with balances:

$

$

$

$

In the past 60 months, has there been any transfer, change of ownership of any real estate, including creating a life estate, even if 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:

Relationship:

Address:

City:

State: Zip:

Phone:

Email:

Please provide a copy of Power of Attorney, Guardianship appointment and Health Care Proxy if applicable.

ATTORNEY HANDLING AFFAIRS (IF APPLICABLE)

Name:

Address:

City:

State: Zip:

HEALTHCARE FACILITY HISTORY

Please disclose any admissions/confinements to any other healthcare facilities in the past 12 months:

Facility name and dates

Facility name and dates

SIGNATURE

Relationship:

Date:

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:

ATTN: Admissions, D'Youville Senior Care, 981 Varnum Avenue, Lowell, MA 01854

Tel. 978-569-1000
Fax. 978-349-2062