Elizabeth Seton
RESIDENCE
Skilled Nursing and Rehabilitation
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:

_____

_____

___ Please attach a recent primary care physician's medical summary or recent note.

___ 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.

MENTAL STATUS/BEHAVIOR OF APPLICANT

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

___ Alert and Oriented	___ Poor Short Term Memory	___ Poor Long Term Memory
___ Depressed	___ Anxious	___ Agitated
___ Wanders	___ Aggressive	___ Cooperative with Care
___ Follows Directions	___ Social	___ Enjoys Group Activity
___ Agreeable to Admission		

The following information is <u>required</u> 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:

Name : _____

Address: _____

City/State: _____ZIP: _____

Telephone Numbers: (H) _____

(W) _____ Cell _____

E-mail _____

Power of Attorney:

Name: _____

Address: _____

City/State: _____ZIP: _____

Telephone Numbers: (H) _____

(W) _____ Cell: _____

E-mail _____

Next of Kin:

Name: _____

Address: _____

City/State: _____ ZIP: _____

Phone Numbers: (H) _____

(W) _____ Cell _____

E-mail _____

Additional Emergency Contact Names:

Name: _____

Relationship: _____

City/State: _____ ZIP: _____

Phone Numbers: (H) _____

(W) _____ Cell: _____

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:

_____

_____