APPLICATION FOR LONG-TERM ADMISSION

The following is an application for long-term admission to our facility. Criteria for admission are the same for all persons without regard to race, gender, age or national origin.

Name _____

Address

_____

_____**Telephone** _____

Date of
Birth _____ **Age**_____ **Sex**_____ **Religion**_____

Marital Status_____ **Funeral Director** _____

Primary Language _____

What type of care are you interested in (circle one)? Long-term or Memory Care

RELATIVES OR SIGNIFICANT OTHERS

Person to be notified in an emergency:
(First)
Name _____Telephone# (H)_____(W)_____
Address_____Relationship_____

(Second)
Name _____Telephone# (H)_____(W)_____
Address_____Relationship_____

PHYSICIANS/HOSPITALIZATIONS

Primary Care_____Address_____Phone_____
Date of last visit_____ Will physician follow in Nursing Home? Yes_____ No_____

Nursing Home or Rehab Facility utilized within 6 moths
Name_____ Address_____
Dates_____
Reason_____

FINANCIAL/BILLING INFORMATION

Federal Medicare# _____
State Medicaid#_____ Effective Date_____
Social Worker _____
Telephone#_____
District Office _____

By definition, a patient in Rhode Island is considered private paying until their individual assets are spent down to the R.I. Medicaid Eligibility Limit $4,000.00. Anyone who has less than $4,000.00, upon application, would be eligible to apply for R.I. Medicaid Assistance through the R.I. Department of Human Services, prior to admission. In order for our home to project the Private Pay and Medicaid Census, we request your assistance in completing the following questions.

Based on the above criteria, the applicant would be: (Please circle one)
Private Pay or Medicaid Eligible
If there is a need for Medicaid Long Term Care Assistance, the applicant has:
_____ Already applied with a decision of eligibility
_____ Already applied with decision pending
_____ Not begun application yet
_____ A need to obtain further information regarding how to begin the decision process of Medicaid application.

FINANCIAL RESPONSIBLE PARTY (individual responsible for payment of account)

Name_____ Address _____
Home Phone# _____Work Phone#_____ Relationship_____

Name_____ Address _____
Home Phone# _____Work Phone#_____ Relationship_____

CURRENT MONTHLY INCOME & ASSETS

	Amount
Savings Accounts	_____
Checking Accounts	_____
Real Estate owned	_____
Social Security	_____
Pension	_____
Stocks & Bonds	_____
Investment Income	_____
Other (Long-term Care, Veterans, etc.)	_____

PLEASE LIST ADDITIONAL BANKS & ACCOUNT AMOUNTS ON THE BACK OF THIS FORM.

I fully understand that this is just an application for the waiting list. I also understand that after acceptance for admission, a physical examination by your primary physician or by your Medical Director is required before admittance to the facility. The examination is for medical evaluation and to insure proper placement for level of care.

Applicant's
Signature_____ Date_____