REST HOME APPLICATION

Admissions / Screening Contact Info

Kim Cooper, Admissions Director
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***Preferred Rest Home / Location** (circle one)*

Ivy Hill Assisted Care Kim Cooper, Manager 978-374-8861 x222 337 Main Street Haverhill, MA 01830 www.ivyhillassistedcare.com	Crescent Manor Mary Lizotte, Manager 508-839-2124 5 Crescent Street Grafton, MA 01519 www.crescentmanorresthome.com	Brookhaven Assisted Care Erin Tierney, Manager 508-867-3325 19 West Main Street West Brookfield, MA 01585 www.brookhavenassistedcare.com	Elizabeth Catherine Resthome Irlande Aime, Manager 781-337-0772 27 Front Street Weymouth, MA 02188 www.ec-sm.com

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Admission Application

Date: _____

Applicant Information:

Full Name: _____ Date of Birth: _____ SS # _____

Home Address: _____ Tele: _____

_____

Present Address: _____ Tele: _____

_____

Contacts: Circle all that apply: Relative / Friend / Guardian / Power of Attorney / Health Care Proxy / Social Worker / Case Manager

Person 1. Name: _____Tel: _____Email: _____

Full Address: _____

_____

Person 2. Name: _____Tel: _____Email: _____

Full Address: _____

_____

Applicant information:

Sex: _____ Height: _____ Weight: _____ Religion: _____ Marital Status: _____

Drug Allergies: _____

_____

_____

Vaccinations / Molst Information

List the Date of:

_____ MOLST

_____ Flu shot
_____ Pneumonia shot
_____ Tuberculosis test
_____ Shingles Shot

List the Date of:

_____ Covid Test (most recent)

_____ Covid-19 Vaccination Type (Pfizer, Moderna, etc)
_____ Covid-19 1st Shot
_____ Covid-19 2nd Shot
_____ Covid-19 Booster
_____ Covid-19 Previously Positive

Medication Information: Current Diagnosis and Current Medications (Required unless supplied from Hospital, Doctor or Rehab)

_____

_____

Guardianship / POA / Living Will / Other:

Do you have a Living Will? ❑ Yes ❑ No (❑ copy attached)

Durable Power of Attorney? ❑ Yes ❑ No (❑ copy attached)

Name: _____ Tel: _____

Address: _____

Do you have a Guardian? ❑ Yes ❑ No (❑ copy attached) **Is the Guardian Invoked?** ❑ Yes ❑ No (❑ copy attached)

Name: _____ Tel: _____

Address: _____

Other? ❑ Yes ❑ No (❑ copy attached)

Name: _____ Tel: _____

Address: _____

Clinical Status:

Category	Circle applicable from each category				Notes
Vision	Glasses	Legally Blind	Cataracts	Glaucoma	
Mouth	Teeth	Dentures	Partial	Bridge	
Hearing	Aids (L)	Aids (R)	Deaf	Tubes	
Mobility	Indep / Stairs	Cane / Walker	Rollator	Wheelchair	
Skin	Dry / Thin	Moles	Rashes	Edema	
Other					

Falls: # of falls within the past year: _____ Falls requiring ER in the past year _____

Therapy: Physical Therapy / Occupational Therapy / Speech Therapy / Psych Services (circle)

Brief Explanation: _____

Current Support Needs of Applicant: (Ivy Hill does not provide 1:1 Assistance)
(prosthetic devices, ted stocking, Continued PT, OT, ST, etc.)

Brief Explanation: _____

Activities of Daily Living: Circle appropriate ADL's / IADL's

Category	Circle applicable from each category				Notes /Other
Bathing	Setup	Supervision	Min / Mod	Maximum	
Dressing / Grooming	Setup	Supervision	Min / Mod	Maximum	
Mobility	Setup	Supervision	Min / Mod	Maximum	
Toileting Assist	Setup	Supervision	Min / Mod	Maximum	
Toileting Level	Indep.	Assist.	Incont. Urine	Incont. Bowels	
Toileting Tools	Commode / Urinal	Pads	Pull-ups	Briefs	
Sleeping	Bed Rails	Up at night	Sound sleeper	Sleep walker	
Safety Concerns (please explain)	Cognitive	Behavioral	Medication	Other (please explain)	

Current Mental Status and Behavior: Circle appropriate status / behaviors

Alert & Oriented (x 1, 2, 3, 4)	Forgetful	Irritable	Agitated	Anxious	Cooperative
Uncooperative	Combative	Aggressive	Depressed	Withdrawn	Suicidal
Withdrawn	Pleasant	Fearful	Delusional	Suspicious	Rational
Wandering	Sexually appropriate	Poor Judgment	Argumentative	Hallucinations	

Other/Notes: (include if applicant will require Mental Health support services from a psychiatrist or therapist)

_____

_____

Applicant's Medical History **Circle appropriate current and previous conditions**

Yes ☐ No ☐ Arteriosclerosis
Yes ☐ No ☐ Atrial Fibrillation
Yes ☐ No ☐ Pacemaker
Yes ☐ No ☐ TIA
Yes ☐ No ☐ Angina
Yes ☐ No ☐ Coronary Artery Disease
Yes ☐ No ☐ Hypertension - (High Blood Pressure)
Yes ☐ No ☐ Hypotension / Syncope
Yes ☐ No ☐ Dizziness
Yes ☐ No ☐ Peripheral Vascular Disease
Yes ☐ No ☐ Edema
Yes ☐ No ☐ Aphasia
Yes ☐ No ☐ Dysphasia
Yes ☐ No ☐ Pneumonia
Yes ☐ No ☐ Asthma
Yes ☐ No ☐ COPD
Yes ☐ No ☐ Smoking
Yes ☐ No ☐ Cancer
Yes ☐ No ☐ Cataracts
Yes ☐ No ☐ Parkinson's Diseases
Yes ☐ No ☐ Neuropathy
Yes ☐ No ☐ Dermatitis
Yes ☐ No ☐ Eczema
Yes ☐ No ☐ Psoriasis
Yes ☐ No ☐ Anemia
Yes ☐ No ☐ Mastectomy
Yes ☐ No ☐ Hysterectomy

Yes ☐ No ☐ Gout
Yes ☐ No ☐ Diabetic Ulcer
Yes ☐ No ☐ Diabetic Yes ☐
Yes ☐ No ☐ Dementia/Alzheimer's
Yes ☐ No ☐ Bipolar Disorder
Yes ☐ No ☐ Schizophrenia
Yes ☐ No ☐ Post Traumatic Stress Disorder
Yes ☐ No ☐ Addiction (alcohol/drugs)
Yes ☐ No ☐ Insomnia
Yes ☐ No ☐ Constipation
Yes ☐ No ☐ Diarrhea
Yes ☐ No ☐ MRSA

Other:

_____

_____

Financial Information (required – will need award letter or proof) *(ALL FINANCIAL INFO TO BE COMPLETED)*

Social Security	_____/ month	LTC Insurance	_____/ month
VA Pension	_____/ month	SSI	_____/ month
2 Bank Statements	_____/ 2 months	Other	_____

Insurance Information

Primary _____ Secondary _____ Medicare # _____

Mass Health # _____ Other Ins# _____

Asset Information (List current assets or assets)

Real Estate / Property:

1. Real Estate: (complete address): _____

Net value: (market value minus mortgage balance) $ _____

2. Real Estate: (complete address): _____

Net value: (market value minus mortgage balance) $ _____

3. Liens/Reverse Mortgage on real estate: (specify) $ _____

Bank Accounts:

Name and address of bank

_____

Account type: _____ Current balance $ _____

Name and address of bank

_____

Account type: _____ Current balance $ _____

Life Insurance:

Company _____ Cash value $_____ Face value $ _____ Company

_____ Cash value $_____ Face value $ _____

Prepaid Burial (Note: $1500 limit for individuals applying for MA Health within one year of admission.)

Location: _____ Is the plan irrevocable? ❑ Yes ❑ No Date purchased _____ Amount $ _____ Burial Account: _____

Bank _____ Amount $_____

THIS PAGE MUST BE FILLED OUT

Rates & Services

(If a Short-term resident stays longer than 90 days the difference between Short-term rate and Long-term rate will be applied to the long term stay.)

At the time an applicant is accepted for admission, the applicant will be asked to pay a $ 300.00 nonrefundable bed-hold deposit. This deposit will be deducted from the 1st month's payment.

Please initial that you understand _____ Date: _____

Basic care includes:

- Meals and snacks planned under the guidance of a licensed dietician
- Housekeeping services and linen
- Pleasantly furnished single rooms
- 24 hour supervision and assistance with In-house activity programs and daily living
- Resident-care planning
- Laundry service daily
- In-house activity program
- Public telephones and private phones in rooms
- Cable TV in Activity Rooms (55" High Definition with surround-sound)
- Medication management with pharmacy service with daily delivery
- Assistance arranging in-house and outside medical, psychiatric, and social

Appointments / Assistance arranging transportation Services and supplies are not covered by the daily rate:

- Hairdresser/Barber
- Prescription medications & other meds not covered as house stock
- **NOTE:** Pharmacy will direct bill MassHealth, most insurance companies and some HMO's. There may be a copay for prescriptions depending on coverage. • Transportation services not covered by insurance will be the responsibility of the resident
- Private attendant accompanying residents to medical appointments. $ 25.00/hr.
- Wander guard bracelets and monitoring - Residents are responsible for the cost of the device
- Physicians' services – services not covered by insurance are the responsibility of the resident
- Personal care items – denture tabs, denture cups, shampoo, powder, toothpaste, toothbrush etc.
- Incontinence supplies - supplies not covered by insurance are the responsibility of the resident
- One-on-one private duty care

Person providing Information for this application

Name: _____
(print name)

Signature: _____ Date: _____