Brookhaven Assisted Care

FACILITY INFO
Brookhaven Assisted Care
19 West Main Street
West Brookfield, MA 01585
Manager: Erin Tierney
Med. Coord: Laura O'Donnell
Financial Info: Nancy Olsen
Phone: 508-867-3325
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Phone (Financial) 774-200-1539
www.brookhavenassistedcare.com/
Erin.brookhaven@gmail.com

ADMISSION / SCREENING INFO
Admissions Director: Kim Cooper
Email: resthome.admissions@gmail.com
Cell: 978-500-2680
Fax: *978-374-2109* ***(under 25 pgs please)***
E-Fax: ***1-978-926-2651*** (preferable)

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: (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 & Orientated (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 ☐ Diabetic Ulcer
Yes ☐ No ☐ Diabetic Yes ☐
Yes ☐ No ☐ Gout
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)

Social Security ____________/ month LTC Insurance ____________/ month

VA Pension ____________/ month SSI ____________/ month

***Must PROVIDE 3 most recent Bank Statements** 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 $___________

Long Term Care Insurance: (typically a resident with LTC Insurance will be Private Pay status)

Rates & Services (subject to change)

- Private Pay rates & Respite Care rates will be set and discussed with Management (rates are subject to change)
  (**If a Respite/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.)
- Residents who cannot afford to pay privately will need to apply for a qualifying ***supplemental program*** that is offered by the State of Massachusetts. *The facility manager will explain and coordinate the application process.
- At the time an applicant is accepted for admission, the applicant will be asked to pay a pro-rated, nonrefundable bed-hold deposit. This amount will be provided by the Facility Manager.

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 outside transportation, medical, psychiatric, and social appointments

Services & Supplies NOT Covered: (resident will be responsible for these services/charges)

- Hairdresser/Barber
- Prescription medications & other meds not covered as house stock
- **NOTE:** Pharmacy will direct bill Mass Health, most insurance companies and some HMO’s.
  *There may be a co-pay 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 (discuss with management-some facilities do not allow)
- 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:** ________________