Brookhaven Assisted Care
19 West Main Street
West Brookfield MA 01585
P - 508-856-3325
F - 508-637-1318 (Manager Private Fax)
F - 774-449-8197 (Nurse Station Fax)

Office Manager - Donna Nairn
Medical Coordinator - Laura O'Donnell
Financials - Nancy Olson

Admission Application **Date of Application:** _____

Potencial Resident Information:

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

Home Address: _____ Telephone: _____

Present Address: (rehab, hospital, skilled nursing) _____ Telephone: _____

Medicare # _____ Mass Health # _____ Other: _____

Health Insurance Company: _____ Telephone: _____

ID # _____ Prescription Coverage: _____

Long Term Care Insurance Provider: _____

Contact for Admission purposes:

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

Person 1. Name: _____ Relationship: _____

Telephone: Cell - _____ Home - _____ Email: _____

Full Address: _____

Contact for Admission purposes:

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

Person 2. Name: _____ Relationship: _____

Telephone: Cell - _____ Home - _____ Email: _____

Full Address: _____

Resident information:

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

Drug Allergies: _____

List the Date of:

_____ MOLST _____ Flu shot _____ COVID Test
_____ Pneumonia shot _____ Shingles shot _____ Tuberculosis test

Current Diagnosis and Medications: _____

_____

_____

_____

Difficulty communicating? ❑ Yes ❑ No If yes Explain: _____
Trouble naming familiar objects etc. ❑ Yes ❑ No Explain: _____
Vision: _____ Good _____ Glasses _____ Legally Blind
Mouth: _____ Own Teeth _____ Dentures _____ Partial Denture _____ Bridge
Hearing: _____ Good _____ hearing aids (L) _____ hearing aids (R) _____ Deaf _____ sores in the mouth
Walking: _____ Independent _____ Cane _____ walker with a seat _____ Standard Walker _____ Climb Stairs
Skin: _____ Normal _____ Dry _____ Flaky _____ Thin _____ Moles _____ Rashes _____ Edema
Signature of Person providing Information for this application _____ Date _____

Number of fall with in the past year: _____ How many times sent to ER in the past year and why: _____

Has had a fall evaluation within the last year and with whom: Please provide forms. _____
Has the applicant banged his/her head or had head injuries within the last 3 years? ❑ Yes ❑ No _____
Is there any reason why the applicant, family and or HCP believes the applicant will be at risk for fall? _____
Any head injuries within the past 3 years: _____
Has this applicant had Physical Therapy ❑ Yes ❑ No, Occupational Therapy ❑ Yes ❑ No, speech ❑ Yes ❑ No, Psych within the last year?

Current Support Needs of Applicant:
Special Care needs: ❑ Yes ❑ No _____
Will the applicant require one-on-one supervision? ❑ Yes ❑ No if yes, give reason: _____
Will the applicant require one-on-one assistance? ❑ Yes ❑ No If yes, give reason: _____

Needs help with:
Grooming ❑ Yes ❑ No Bathing ❑ Yes ❑ No Dressing ❑ Yes ❑ No TEDs Stockings ❑ Yes ❑ No Dressing ❑ Yes ❑ No

Toilet Habits: check all that apply
❑Independent ❑ Assistance ❑ Incontinence Urine ❑ Incontinence Bowels
❑Wears: ❑ Pads ❑ Pull-ups ❑ Diapers ❑ Other-explain: _____
Sleeping:
Any special Equipment required (bed rails / commode / Urinal, etc.): _____
Trouble sleeping though the night: ❑ Yes ❑ No if yes why: _____

Current Mental Status and Behavior:
Has the applicant had a comprehensive Geriatric Med-Psych Assessment? ❑ Yes ❑ No Date: _____

Fill in or circle appropriate status / behaviors:

Alert Oriented Confused Forgetful Rational Fearful Agitated Anxious

Cooperative Uncooperative at times Combative Violent Aggressive Depressed Withdrawn

Suicidal Pleasant Pleasantly confused Fearful Fretful Agitation delusions suspicious

Other & explain: _____

Behavioral issues in the last 3 years: _____

Memory loss: Short Term Long Term

Behavioral issues (last 3 years): _____

Has the applicant had Physical Therapy within the last year? ❑ Yes ❑ No _____

Sexually: Appropriate ❑ Yes ❑ No Inappropriate ❑ Yes ❑ No

Difficulty with judgment? ❑ Yes ❑ No if yes explain: _____

Episodes of wandering or getting lost? ❑ Yes ❑ No If yes explain: _____

Is the applicant able to go out for a walk and return to Ivy Hill with no problem. ❑ Yes ❑ No if yes explain: _____

Does the applicant misplace items. ❑ Yes ❑ No If yes explain: _____

Does the applicant show poor judgment and loss of ability to recognize danger? ❑ Yes ❑ No If yes explain: _____

Has the applicant been having hallucinations, arguments, striking out, delusions, agitation, depression or violent behaviors? ❑ Yes ❑ No

Is this applicant cognitively impaired? ❑ Yes ❑ No if yes explain: _____

Does this applicant have any prosthetic devices ❑ Yes ❑ No if yes explain: _____

Is there any information you can provide that might be important or relevant history? That would help us care for your loved one._____

_____

If Applicant is coming from a Skilled Nursing Facility, describe reason/circumstance for admission to the Skilled Nursing Facility: _____

_____

Signature of Person providing Information for this application _____ **Date** _____

Declaration of Finances:

Please note **Brookhaven** has a limited # of MA Health beds. If applicant will be using or applying for MA Health as a source of payment within 1 year of admission, please provide the following information:

Social Security ..... $ _____/month
VA Pension ..... $ _____/month
LTC Insurance ..... $ _____/month
..... $ _____/month
MA Health # _____ SSI..... $ _____/month

Assets (List current assets or assets owned within the last 5 years. Any transfer of assets may disallow an individual from MA Health eligibility.)

Real 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) _____ $_____

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

Bank Accounts:

1. Name and address of bank _____
   Account type_____ Current balance $_____
2. Name and address of bank _____
   Account type_____ Current balance $_____
3. Name and address of bank _____
   Account type_____ Current balance $_____

Investment Accounts:

Company_____ Type_____ Current balance $ _____
Company_____ Type_____ Current balance $ _____

Stocks and Bonds:

Location _____ Type (stock/bond etc.)_____ Current value $ _____
Location _____ Type (stock/bond etc.)_____ Current value $ _____

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 $_____

Transferred Assets

Has applicant liquidated assets and/or transferred funds/assets to another person within the last 5 years? ❑ Yes ❑ No

List cash, type of fund/assets, dates and to whom _____

FINANCIAL (please provide copies of all cards front and reverse)

Social Security # _____Social Security Amount $ _____/month

Medicare # _____Medicare Part D Prescription #_____Medex _____

Other Income	SOURCE	AMOUNT	PER
		$_____/	_____
		$_____/	_____
		$_____/	_____

Other Insurance_____ID # _____Tel. _____

MA Health # _____

Signature of Person providing Information for this application _____ **Date** _____

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

Name of Company _____Tel. _____

Address _____

Trust Fund: (typically a resident with payment source of a Trust Fund will be Private Pay status)

Name of Manager _____Tel. _____

Address _____

Are you a Veteran? ❑ Yes ❑ No Is/was your spouse a Veteran? ❑ Yes ❑ No Disability ❑ Yes ❑ No

Veteran ID # _____VA Pension .....$_____

Dates of service_____to _____Award letter (❑ copy attached)

VA Contact Name _____Phone_____

Address _____

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

Do you have a Durable Power of Attorney? ❑ Yes ❑ No.....(❑ copy attached)

Name_____ Phone _____

Address _____

Do you have a Guardian? ❑ Yes ❑ No .....(❑ copy attached)

Name_____ Phone _____

Address _____

Do you have a Conservator? .....(❑ copy attached)

Name_____ Phone _____

Address _____

FINANCIAL Declaration of Finances with Spend-down

Applicants who plan to apply for MA Health within five years of admission to **Brookhaven** must complete and document a proper spend-down to ensure eligibility and bed availability. **Brookhaven** maintains 15 MA Health beds.

This page must be filled out if an application for MA Health is anticipated within 5 years.

Responsible Party/Guarantor is an individual responsible for assistance in resident's bill payment. This individual is not personally financially responsible for the resident's bills. However, a resident's financial manager, the individual who manages the resident's money, is responsible for proper management and keeping records of the resident's finances so as to prepare for a proper spend-down should financial assistance be needed at a later date. An improper Spend-Down or diversion of funds will render an applicant ineligible for public assistance. Brookhaven is happy to provide assistance with MA Health Applications should the need arise.

PLEASE PROVIDE SUPPORTING DOCUMENTATION

Applicant Name _____

Responsible Party / Guarantor Name _____Tel. _____

Relationship to resident_____

Financial Manager's Name _____Tel. _____

Relationship to resident_____

Name of Consultant Firm advising / assisting with Spend-down plan. Contact name: _____Phone: _____

"Spend-down" for Residential Care - Level IV is different from a "Spend-down" for a Skilled Nursing Facility.

Signature of Person providing Information for this application _____ Date _____

Assets / Real Property: (list current assets or assets owned within the last 5 years)

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)_____ $_____

4. Automobile: Make _____Model _____Year _____Estimated value $_____

   Date sold _____Actual net monies $_____

5. Misc. _____ $_____

Bank Accounts:

1. Name and address of bank _____

   Account type_____ Current balance $_____

2. Name and address of bank _____

   Account type_____ Current balance $_____

3. Name and address of bank _____

   Account type_____ Current balance $_____

Private Room 1st and 2nd floor - Shared bathroom, adjoining bathroom, private half bathroom, private full bath, Private rooms and semi-private rooms, run from $170.00 to $255.00 a day

(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: _____

REDUCED PRIVATE PAY-RATE: There are times when an individual is not eligible for MA Health because their income is too high and yet they do not have enough funds for the full Private-Pay rate. **Brookhaven** will review financials to see if an individual would qualify for a reduced Private-Pay rate. Applicants may speak directly to the Administrator regarding the possibility of a reduced Private-Pay rate. The minimum Reduced Private Pay rate is $95.00 a day.

Basic care includes:

- Meals and snacks planned under the guidance of a licensed dietician
- Housekeeping services and linen
- Pleasantly furnished room
- 24 hour supervision and assistance with In-house activity programs and daily living
- Resident-care planning
- Laundry service daily
- In-house activity program
- Public telephone
- 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 not covered by the daily rate:

- Hairdresser / Barber
- Private Phone
- 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 resident 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

(5) Signature of Person providing Information for this application _____ *Date* _____

Please check off yes or no Sign that all is accurate to your knowledge: _____

Yes □ No □ Arteriosclerosis
Yes □ No □ Cardiac Dysrhythmias
Yes □ No □ Atrial Fibrillation
Yes □ No □ Pacemaker Date: _____
Yes □ No □ Stroke Date: _____
Yes □ No □ TIA Date: _____
Yes □ No □ Angina
Yes □ No □ Heart Failure
Yes □ No □ Cardiomyopathy
Yes □ No □ Coronary Artery Disease
Yes □ No □ Hypertension - (High Blood Pressure)
Yes □ No □ Hypotension / Syncope
Yes □ No □ Orthostatic Hypotension
Yes □ No □ Dizziness

Yes □ No □ Peripheral Vascular Disease
Yes □ No □ Edema
Yes □ No □ Aphasia
Yes □ No □ Dysphasia
Yes □ No □ Emphysema
Yes □ No □ Pneumonia
Yes □ No □ Asthma
Yes □ No □ COPD
Yes □ No □ Smoking
For how long _____ Since last smoked _____
Yes □ No □ Cancer

Yes □ No □ Tumor
Yes □ No □ Gall bladder
Yes □ No □ Gastrointestinal Hemorrhage

Yes □ No □ Cataracts
Cataract Surgery Date: _____ Eye: ___

Yes □ No □ Difficulty Swallowing
Yes □ No □ Coking
Yes □ No □ Anorexia
Yes □ No □ Malnutrition
Yes □ No □ Dehydration
Yes □ No □ Obesity Weight: _____
Yes □ No □ Multiple Sclerosis
Yes □ No □ Parkinson's Diseases
Yes □ No □ Neuropathy
Yes □ No □ Lyme disease
Yes □ No □ Organic Brain Syndrome
Yes □ No □ Delirium Type: _____

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 □ No □ Neuropathy
Yes □ No □ Gout
Yes □ No □ Vitamin Deficiency

Yes □ No □ Alzheimer's before age 60
Yes □ No □ Alzheimer's after age 60
Yes □ No □ Dementia
Yes □ No □ Memory Impairment

Yes □ No □ Anxiety Disorder
Yes □ No □ Anti-anxiety medication
Yes □ No □ Depression
Yes □ No □ Psychosis
Yes □ No □ Bipolar Disorder
Yes □ No □ Schizophrenia
Yes □ No □ Paranoia
Yes □ No □ Personality Disorder Type: _____
Yes □ No □ Post Traumatic Stress Disorder

Yes □ No □ Alcohol Use
Drinks per day _____
Yes □ No □ Street Drugs
Yes □ No □ Intoxication from Medication
Yes □ No □ Abuse of Prescription Drugs
Name: _____
Yes □ No □ Hospitalized: alcohol . Drug related
Yes □ No □ Overmedication
Yes □ No □ Adverse drug interaction

Yes □ No □ Insomnia
Yes □ No □ Sleep medication
Yes □ No □ Sleep / Wake reversal

Yes □ No □ Head Trauma
Yes □ No □ Brain Bleed

Yes □ No □ Constipation
Yes □ No □ Fecal
Yes □ No □ Impaction
Yes □ No □ Diarrhea

Yes □ No □ MRSA
Colonized _____ Location _____
Yes □ No □ TB Date: _____
Date of last TB test _____
Yes □ No □ Cellulitis
Yes □ No □ Infection
Yes □ No □ Chronic Infection
Yes □ No □ Other

_____

_____

_____

_____