



Application for Admission

Holden _____ **Oakdale** _____

NAME: _____	DATE OF APPLICATION: _____
ADDRESS: _____ _____	SOCIAL SECURITY #: _____
TELEPHONE: _____	MEDICARE #: _____
DATE OF BIRTH: _____ AGE: _____	MEDEX I,II, OR III: _____
BIRTHPLACE: _____ CITIZEN: _____	OTHER INSURANCE: _____
RELIGION: _____ MARITAL STATUS: _____	MEDICAID #: _____
SPOUSE: _____	MASS HEALTH #: _____
IF DECEASED, DATE OF DEATH: _____	LTC SCREENING: YES _____ NO _____ (IF YES SEND COPY)
	FATHER'S NAME: _____
	MOTHER'S MAIDEN NAME: _____

WORK HISTORY, PREVIOUS OCCUPATION

PREVIOUS OCCUPATION (WORK DONE DURING MOST OF LIFE, EVEN IF RETIRED) _____

EDUCATION LEVEL: _____ PRIMARY LANGUAGE: _____

WERE YOU IN THE ARMED FORCES? _____ DATE OF SERVICE: _____

CURRENT STATUS OF APPLICANT

APPLICANT IS NOW AT: _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

CONTACT PERSON: _____ TELEPHONE _____

PHYSICIAN: _____ TELEPHONE _____

ADDRESS: _____ CITY _____ STATE _____ ZIP _____

MEDICAL DIAGNOSIS: _____

FINANCIAL MANAGER

NAME: _____ RELATIONSHIP _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
TELEPHONE(HOME) _____ CELL _____ WORK _____
IF THERE A POWER OF ATTORNEY _____ IF YES PROVIDE COPY _____

FINANCIAL INFORMATION-SOURCES OF INCOME

<u>TYPE</u>	<u>RECIPIENT NAME</u>	<u>MONTHLY INCOME</u>
SOCIAL SECURITY	_____	_____
RETIREMENT (PENSION)	_____	_____
VA PENSION	_____	_____
RENTAL INCOME	_____	_____
ANNUITIES/INVESTMENTS	_____	_____
OTHER(SPECIFY)	_____	_____

FINANCIAL INFORMATION-ASSETS

<u>NAME OF BANK</u>	<u>TYPE OF ACCOUNT</u>	<u>VALUE</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

DO YOU OWN: STOCKS: _____ BONDS _____ CD'S _____ MUTUAL FUNDS _____

APPROXIMATE VALUE _____

INSURANCE COMPANY _____ POLICY NUMBER _____ FACE VALUE _____

HAVE YOU CREATED A TRUST? _____

DO YOU OWN YOUR HOME? YES _____ NO _____ LIVE ALONE? YES _____ NO _____

DO YOU HAVE LONG TERM CARE INSURANCE? YES _____ NO _____

NAME OF COMPANY _____ POLICY NUMBER _____

ADDRESS _____ TELEPHONE _____

HAS THER BEEN A TRANSFER OF ASSETS IN THE LAST 5 YEARS? YES _____ NO _____ IF SO PLEASE EXPLAIN:

RESPONSIBLE PARTY

NAME _____ RELATIONSHIP _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
TELEPHONE _____ CELL _____ WORK _____
EMAIL: _____
IS THERE A HEALTH CARE PROXY/POWER OF ATTORNEY? _____ IF YES PROVIDE COPIES

EMERGENCY NOTIFICATION

NAME _____ RELATIONSHIP _____
COMPLETE ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ CELL _____ WORK _____

NAME _____ RELATIONSHIP _____
COMPLETE ADDRESS _____ CITY _____ STATE _____ ZIP _____
PHONE _____ CELL _____ WORK _____

BURIAL ARRANGEMENTS

FUNERAL HOME _____ TELEPHONE _____
ADDRESS _____

*I hereby state that to the best of my knowledge and belief, the above stated information is true, correct and complete. All of the information will be kept confidential by Oriol Health Care and will not be released without written permission.

SIGNATURE OF APPLICANT _____ DATE _____

SIGNATURE OF RESPONSIBLE PARTY _____ DATE _____

Please mail/email or fax back to:
Oriol Health Care
52 Boyden Road, Ste. 209
Holden, MA 01520
Attn: Tina Sibley, Admissions Director
Telephone: (508) 829-1111 Fax: (508) 829-1269
Email: tsibley@oriolhealthcare.com