



**APPLICATION FOR ADMISSION**

Facility Choice: Holden \_\_\_\_\_ Oakdale \_\_\_\_\_ Wachusett Respiratory Unit \_\_\_\_\_

Applicant's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip code

Telephone #: \_\_\_\_\_ U.S. Citizen:  YES  NO Sex: M/F

Religion: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Were you in the armed forces? \_\_\_\_\_ If so, Dates of service: \_\_\_\_\_

Marital Status:  Married  Divorced  Widowed  Separated  Never Married

Name of Spouse: \_\_\_\_\_ Primary Language: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Financial Manager**

(Please provide the information below for the person(s) who handles financial matters for the applicant)

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip code

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Please check type of authority (if any) and provide a copy with this application:  
 Legal Guardian  Durable Power of Attorney  Conservator  Representative Payee

**Health Care Proxy**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_  
Street City State Zip code

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

\*Please include a copy of the health care proxy with this application

If no health care proxy please provide the name of an emergency contact:  
 Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

**Current Living Situation**

Applicant is currently living at: \_\_\_\_\_

Does applicant live alone?  Yes  No with whom? \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone: \_\_\_\_\_

Readiness for placement:  ASAP  currently in the Hospital  planning for the future

**List any recent inpatient admissions (within the Last year)**

Hospital: \_\_\_\_\_ Dates: \_\_\_\_\_

Rehab Facility: \_\_\_\_\_ Dates: \_\_\_\_\_

Nursing Home: \_\_\_\_\_ Dates: \_\_\_\_\_

If not hospitalized within last year please give date of last physical exam: \_\_\_\_\_

Has applicant ever been admitted to a state hospital or psychiatric unit?  YES  NO

Name: \_\_\_\_\_ Dates: \_\_\_\_\_

Primary Medical Diagnosis: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Health Insurance**

Medicare #: \_\_\_\_\_  Part A only  Part B only  Part D  Part A & B

Part D Prescription coverage provider: \_\_\_\_\_ ID #: \_\_\_\_\_

HMO Name: \_\_\_\_\_ ID #: \_\_\_\_\_

Massachusetts Medicaid (Mass Health) #: \_\_\_\_\_

Long Term care insurance: \_\_\_\_\_ Policy#: \_\_\_\_\_

**Monthly Income**

<b><u>Type</u></b>	<b><u>Recipient Name</u></b>	<b><u>Amount</u></b>
Social Security	_____	\$ _____
Retirement (Pension)	_____	\$ _____
VA Pension	_____	\$ _____
Rental Income	_____	\$ _____
Other	_____	\$ _____

**Financial Information/Assets**

<b><u>Name of Bank:</u></b>	<b><u>Type of account:</u></b>	<b><u>Amount:</u></b>
_____	_____	\$ _____
_____	_____	\$ _____
_____	_____	\$ _____

Do you own:  Stocks  Bonds  CD's  Mutual Funds      Approximate Value: \$ \_\_\_\_\_

Life insurance policy: Company name: \_\_\_\_\_ Policy#: \_\_\_\_\_

Beneficiary Name: \_\_\_\_\_ Face Value: \_\_\_\_\_

Have you created a trust:  YES  NO    If so what type: \_\_\_\_\_

Do you own your home?  YES  NO

Has there been a transfer or gift of more than \$750.00 in the past 5 years?  YES  NO

If yes please explain: \_\_\_\_\_

**\*PLEASE NOTE IF YOU ARE APPLYING FOR MASS HEALTH (MEDICAID), THE LOOK BACK PERIOD IS 5 YEARS. THIS IS TO DETERMINE WHETHER THERE HAVE BEEN ANY DISQUALIFYING ASSET TRANSFERS.**

**Funeral/Burial Arrangements**

Funeral Home: \_\_\_\_\_ Telephone#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Have arrangements been pre-paid?  YES  NO

Do you have an account set up for Burial/Funeral expenses?  YES  NO

I hereby state to the best of my knowledge and belief, the above stated information is true, correct and complete.

I understand that if any information has been falsely represented, this will be a sufficient cause for voiding this application for admission

\*All of the information will be kept confidential by Oriol Health Care and will not be released without written permission.

Signature of Applicant (If able): \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Application Check list: Please include the following documentation with this application:

- Completed application form
- Copies of applicant's insurance cards
- Copies of any of the following that apply:
  - Power of Attorney
  - Health Care Proxy
  - Guardianship
  - Conservatorship

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Please Mail/E-Mail or Fax to one of the Following:

Oriol Health Care  
Attn: **Holden & Oakdale** Admissions-LTC  
52 Boyden Road Suite 209  
Holden, MA 01520  
Email: Admissions@oriolhealthcare.com  
Fax: 508-829-1277  
For Inquiries or assistance please contact:  
Tina Sibley at 508-829-1111

Oriol Health Care  
Attn: **Wachusett Resp Unit** Admissions  
52 Boyden Road Suite 209  
Holden, MA 01520  
Email: KMongeon@oriolhealthcare.com  
Fax: 508-829-1277  
For inquiries or assistance please contact:  
Kristin Mongeon, LPN at 774-764-8656