ORIOL HEALTH CARE
Our family taking care of yours

Application for Admission

Holden _____ Oakdale _____

NAME: _____

ADDRESS:_____

_____

TELEPHONE:_____

DATE OF BIRTH:_____AGE:_____

BIRTHPLACE:_____CITIZEN:_____

RELIGION:_____MARITAL STATUS:_____

SPOUSE:_____

IF DECEASED, DATE OF DEATH:_____

DATE OF APPLICATION:_____

SOCIAL SECURITY #:_____

MEDICARE #:_____

MEDEX I,II, OR III:_____

OTHER INSURANCE:_____

MEDICAID #:_____

MASS HEALTH #:_____

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

TYPE	RECIPIENT NAME	MONTHY INCOME
SOCIAL SECURITY	_____	_____
RETIREMENT (PENSION)	_____	_____
VA PENSION	_____	_____
RENTAL INCOME	_____	_____
ANNUITIES/INVESTMENTS	_____	_____
OTHER(SPECIFY)	_____	_____

FINANCIAL INFORMATION-ASSETS

NAME OF BANK	TYPE OF ACCOUNT	VALUE

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