



## APPLICATION FOR ADMISSION

### I. HOW DID YOU LEARN ABOUT US:

\_\_\_\_\_

\_\_\_\_\_

### II. GENERAL INFORMATION:

Background information:

Applicant's Name \_\_\_\_\_

Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M ( ) F ( )

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

Marital Status: ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

Home Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Is the Applicant a US citizen? Yes ( ) No ( )

Education:

8<sup>th</sup> Grade or less ( ) 9<sup>th</sup>-11<sup>th</sup> Grades ( ) High School Graduate ( )

Technical/Trade School ( ) Some College ( ) Bachelor's Degree ( )

Graduate Degree ( )

Previous Occupation: \_\_\_\_\_ Military: \_\_\_\_\_

Religion: \_\_\_\_\_ Name of Church \_\_\_\_\_

Pastor \_\_\_\_\_ Telephone \_\_\_\_\_

Primary Language \_\_\_\_\_

Is the Applicant aware of the placement decision? Yes ( ) No ( )

Has the Applicant made pre-paid funeral arrangements? Yes ( ) No ( )

Funeral Home Preference \_\_\_\_\_ Telephone \_\_\_\_\_

Is now at: \_\_\_ Home \_\_\_ Hospital \_\_\_ Nursing Home \_\_\_ ALF/Rest Home  
\_\_\_ With Relative \_\_\_ Other: \_\_\_\_\_

Specify facility or caretaker:

Name \_\_\_\_\_

Address \_\_\_\_\_

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

Zip \_\_\_\_\_ Phone \_\_\_\_\_

If spouse or partner is living, please identify:

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Primary Contact Person:

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

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Secondary Contact Person:

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

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

### III. APPLICANT'S MEDICAL INFORMATION:

Does applicant have personal physician? \_\_\_\_\_ Yes \_\_\_\_\_ No

If YES, please identify:

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_

Will Physician Follow Resident at Holy Trinity? \_\_\_\_\_ YES \_\_\_\_\_ NO

Current Medical Condition:

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How long has this problem existed?

Past Medical Condition:

Current Medications:

Please list all home based services the applicant receives including home health aid services, nursing services, Meals on Wheels, live in caretakers, and live in family members. (If applicant has received "live in" services please identify caregiver, and for how long):

Applicant's last hospitalization(s):

Name of Hospital \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Dates of Stay \_\_\_\_\_

Name of Hospital \_\_\_\_\_  
Diagnosis \_\_\_\_\_  
Dates of Stay \_\_\_\_\_

Previous Nursing Home or Rehabilitation Center Admission(s):

Name of the Facility \_\_\_\_\_  
Reason for Admission \_\_\_\_\_  
Dates of Stay \_\_\_\_\_  
Identify problems or concerns: \_\_\_\_\_

Name of the Facility \_\_\_\_\_  
Reason for Admission \_\_\_\_\_  
Dates of Stay \_\_\_\_\_  
Identify problems or concerns: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Applicant's physical mobility:

\_\_\_walks unassisted \_\_\_uses cane \_\_\_uses walker \_\_\_uses wheelchair  
\_\_\_can self propel wheelchair \_\_\_needs assistance \_\_\_bed bound

Please score applicant's Activities of Daily Living skills:

1= independent 2= needs supervision

3= needs assistance 4= total care

Grooming: \_\_\_\_\_ Dressing: \_\_\_\_\_ Bathing: \_\_\_\_\_ Feeding: \_\_\_\_\_

Is applicant incontinent of: Bowel Y ( ) N ( ) Bladder Y ( ) N ( )

Is applicant's eyesight good? Y ( ) N ( ) Glasses? Y ( ) N ( )

Date of last exam \_\_\_\_\_ Ophthalmologist \_\_\_\_\_

Does applicant wear dentures? Y ( ) N ( )

Date of last dental/ gum exam \_\_\_\_\_ Dentist \_\_\_\_\_

Does applicant hear well? Y ( ) N ( ) Use Hearing Aids? Y ( ) N ( )

Date of last hearing exam \_\_\_\_\_ Audiologist \_\_\_\_\_

Applicant's Special Needs:

Oxygen \_\_\_\_\_ Respirator \_\_\_\_\_ Catheter \_\_\_\_\_ Feeding Tube \_\_\_\_\_

Colostomy/ Ileostomy \_\_\_\_\_ Prosthesis \_\_\_\_\_ Type: \_\_\_\_\_

Diet Restrictions \_\_\_\_\_

Diet Texture Restrictions \_\_\_\_\_

Skin Care issues \_\_\_\_\_

Please describe any other problems that require special care and attention not previously addressed \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Applicant's Mental Status:**

- Does applicant recognize familiar people? Y / N / Sometimes
- Does applicant know where he/she is? Y / N / Sometimes
- Does the applicant know the day and time? Y / N / Sometimes
- Has the applicant ever been diagnosed as mentally ill? Y / N  
Or mentally challenged? Y / N

Please describe any significant event or occurrence you remember about the applicant's mental condition or behavior:

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Please describe applicant's temperament in your own words:

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**\*Please submit the Physician's Report (completed in full by the applicant's physician)**

**IV. OTHER INFORMATION**

Have any of the following been established on the applicant's behalf? If so, please provide a copy of the document(s).

Health Care Proxy Yes ( ) No ( )

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Power of Attorney Yes ( ) No ( )

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Guardianship Yes ( ) No ( )

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Conservatorship Yes ( ) No ( )

Name \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

**V. APPLICANT'S FINANCIAL INFORMATION:** (Please complete Appendix)

Person responsible for managing applicant's finances:

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Medicare Number \_\_\_\_\_ (Please provide copy)  
Medicaid Number \_\_\_\_\_ (Please provide copy)  
Medex Number \_\_\_\_\_ (Please provide copy)  
Other Insurance \_\_\_\_\_ (Please provide copy)

**(PLEASE SUBMIT COPIES OF ALL INSURANCE CARDS.)**

**VI. MEDICAID/MASS HEALTH APPLICATION STATUS:**

1. Does the applicant have a Medicaid application in process? Yes / No  
(If YES, please provide a copy of the application)

If YES, who is the caseworker at the MassHealth long-term care office?

\_\_\_\_\_

Office Location \_\_\_\_\_ Telephone \_\_\_\_\_

2. Has the applicant had an Elder Home Care screening for nursing home eligibility? Yes / No (If YES, please forward a copy with this application.)

3. Does the applicant have Community Based Medicaid/MassHealth? Yes / No

4. Has the applicant ever filed a Medicaid/MassHealth application? Yes / No  
(If YES, please provide a copy of the eligibility determination)

## VII. AUTHORIZATION

HOLY TRINITY EASTERN ORTHODOX NURSING AND REHABILITATION CENTER ACCEPTS ALL RESIDENTS WITHOUT REGARD TO RACE, CREED, COLOR, NATIONAL ORIGIN, SEX, HANDICAP, OR SPONSOR.

I ATTEST THAT THE INFORMATION INCLUDED IN THIS APPLICATION IS TRUE AND CORRECT. AT THE DISCRETION OF HOLY TRINITY, I UNDERSTAND THAT MY BANK REFERENCES AND CREDIT HISTORY MAY BE VERIFIED, AND I WILL AUTHORIZE THIS, IF REQUESTED. I AGREE THAT A PHOTOCOPY SHALL HAVE THE FULL FORCE AND EFFECT AS THE ORIGINAL OF THIS APPLICATION. I ALSO AUTHORIZE THE RELEASE OF ANY NECESSARY MEDICAL INFORMATION OR RECORDS TO HOLY TRINITY FOR THE PURPOSE OF A PRE-ADMISSION SCREENING.

This application must be completely filled out and verified before applicant will be placed on the facility's waiting list.

Enclosures necessary to complete application are:

1. Physician's Report
2. Copy of legal documents, if applicable
3. Copies of insurance card(s)
4. Copy of Medicaid application, if applicable

Signature of Applicant: \_\_\_\_\_

Date: \_\_\_\_\_

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

Date: \_\_\_\_\_

Please send application to: **Angela Penny, Admissions Coordinator**  
**Holy Trinity Nursing & Rehab Center**  
**300 Barber Avenue**  
**Worcester, MA 01606**  
**Telephone: (508) 852-1000**  
**Fax: (508) 854-1622**  
**apenny@htnr.net**  
**www.htnr.net**