MARY ANN MORSE
HEALTHCARE CENTER

45 Union Street ■ Natick, MA 01760 ■ *phone* 508-433-4404 ■ *fax* 508-655-0751 ■ www.maryannmorse.org

APPLICATION FOR ADMISSION

Name _____ Date _____

Address _____ Social Security # _____

City / State / Zip _____ Home phone _____

Date of birth _____ Age _____ Work phone _____

Religion _____ Sex (circle) Male Female

Marital status _____ Spouse name _____

Medicare # _____ Part A / B (circle) Supplement _____

Was the applicant in a nursing home or hospital during the prior 60 days? Provide name and phone:

_____

Any other insurance(s) that will cover nursing home care (please provide policy numbers)

_____

Has the applicant applied, or will be shortly applying for State Medical Assistance? Yes ____ No ____

Medical Assistance # / Medicaid # _____

RESPONSIBLE PERSON *(In planning and decision making for the applicant)*

Name _____ Relationship _____

Address _____ Home phone _____

City / State / Zip _____ Work phone _____

E-mail address _____

Is there a health care proxy? _____ (If yes, please provide copy)

Is there a power of attorney? _____ (If yes, please provide copy)

CURRENT STATUS OF APPLICANT

Allergies _____

Diet _____ Height _____ Weight _____

Primary care physician _____ Phone _____

Will physician attend here? Yes ____ No ____

Medical diagnoses _____

NEEDS OF APPLICANT

Applicant needs help with? Mark with one or more of the following: I = Independent, A = Assist, D = Dependent

Ambulation _____ Bathing / grooming _____ Communication _____

Dressing _____ Eating _____ Toileting _____

Is applicant continent? Bowel: Yes ____ No ____ Bladder: Yes ____ No ____

Please complete side 2

MENTAL STATUS/BEHAVIOR OF APPLICANT *(check all that apply)*

Alert _____ Appropriate _____ Cooperative _____ Oriented _____

Confused _____ Wanders _____ Combative _____ Disoriented _____

FINANCIAL INFORMATION

SOURCES OF MONTHLY INCOME

Social Security _____ $ _____

Retirement / pension _____ $ _____

Annuities / investments _____ $ _____

Other (specify) _____ $ _____

REAL ESTATE ASSETS

Resident owns home? Yes ____ No ____ Approximate value $ _____

Property owned jointly or individually (circle) Name of co-owner(s) _____

Does resident own additional property? Yes ____ No ____ Value $ _____

OTHER ASSETS/INVESTMENTS *(Stocks, Bonds, Mutual Funds, IRAs, Annuities, etc.)*

Name of Bank	Type of account	Value
_____	_____	$ _____
_____	_____	$ _____
_____	_____	$ _____

How did you hear about Mary Ann Morse Healthcare Center? _____

_____

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 sufficient cause for voiding my application for admission. All of the information will be kept confidential by Mary Ann Morse Healthcare Center and will not be released without my permission.

Signature of resident _____ Date _____

Signature of responsible person _____ Date _____

Facility representative _____ Date _____

Comments:

_____

_____

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