HANNAH B.G. SHAW HOME, INC.
299 Wareham Street
Middleboro, MA 02346
Telephone: 508-947-0332
Fax: 508-947-8537

APPLICATION FOR ADMISSION

The following is an application for admission to our Home. Please complete this application, and return it to *Hannah B.G. Shaw Home* to be considered for admission. Criteria for admission are the same for all persons without regard to race, gender, national origin, age, physical or mental impairments or financial resources.

Please complete the following:

Name: _____
(Last) (First) (Middle)

Social Security Number: _____ Sex: ❑ Female ❑ Male

Present Address: _____ Phone (_____) _____

City: _____ State _____Zip _____

Email Address: _____

Date of Birth: _____ Age: _____ Place of Birth: _____

Marital Status: ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated
Spouse's Name: _____

Primary Language: _____ US Citizen? ❑ Yes ❑ No

Are you a veteran? ❑ Yes ❑ No Was/Is Your Spouse a veteran? ❑ Yes ❑ No

Lifetime Occupation: _____ Education: _____

Religion: _____ Place of Worship: _____
Address of Place of Worship: _____

City/State: _____ Phone: _____

How did you hear about this home? _____

Service applying for: ❑ Long-Term Care ❑ Memory Care ❑ Residential Care

RELATIVES OR SIGNIFICANT OTHERS

Person to be notified in an emergency:

Primary Emergency Contact

Name: _____ Telephone (Home): _____
Relationship_____ (Work): _____
Address: _____ (Cell): _____
City: _____ State: _____ Zip: _____
Email Address**:** _____

Alternate Contact

Name: _____ Telephone (Home): _____
Relationship_____ (Work): _____
Address: _____ (Cell): _____
City: _____ State: _____ Zip: _____
Email Address: _____

Other Contact
Name: _____ Telephone (Home): _____
Relationship_____ (Work): _____
Address: _____ (Cell): _____
City: _____ State: _____ Zip: _____
Email Address: _____

PHYSICIANS

Primary Care: _____ Telephone: _____
Address: _____ Fax: _____
Date of last visit: _____ Will Physician follow in Nursing Home? ❑ Yes ❑ No

Physicians consulted in past 2 years:

Name: _____ Telephone: _____
Address: _____ Specialty: _____

Name: _____ Telephone: _____
Address: _____ Specialty: _____

Name: _____ Telephone: _____
Address: _____ Specialty: _____

FINANCIAL/BILLING INFORMATION

HEALTH INSURANCE (Kindly provide front & back copies of all cards.)

Social Security Number: _____
Federal Medicare Number: _____
Medicare Part D Prescription Coverage Number: _____
Medex Number: _____
Other Insurance: _____ Insurance Number: _____
State Medicaid #: _____ Effective Date: _____
District Office: _____
Long Term Care Insurance: _____

ADDITIONAL INFORMATION

DO YOU HAVE A:

*(Please check "yes" or "no" for each item & **attach copy of instrument if checked" yes")***

MOLST ❑ **YES** ❑ **NO**

HEALTH CARE PROXY ❑ **YES** ❑ **NO**
Name: _____ Address: _____

DURABLE POWER OF ATTORNEY ❑ **YES** ❑ **NO**
Name: _____ Address: _____

POWER OF ATTORNEY ❑ **YES** ❑ **NO**
Name: _____ Address: _____

GUARDIANSHIP
Name: _____ Address: _____

DECLARATION OF FINANCES

You are asked to complete the following financial information section of this application. Should you have any questions or concerns, please contact the admissions coordinator. This statement must be completed with copies of bank statements, burial contract, trusts, annuities, stocks, bonds, or life insurance policies the applicant may have. ***This section must be completed to be considered for admission.***

RESPONSIBLE PARTY (Guarantor)
(Individual responsible to assist resident in paying bills. This person is not financially responsible for the resident's bills.)

Name:_____ Relationship to Resident:_____
Home Address: _____ City:_____
State: _____Zip:_____ Telephone:_____
Email Address: _____

ASSETS:

Real Property:

Real Estate Location: _____
Net Value (*market value minus mortgage balance*): _____
Automobile: _____ Make: _____ Model: _____ VIN # _____

Bank Accounts:

Name of Bank	Account Type	Current Balance

Investment Accounts:

Location	Account Type	Current Balance

Stocks and Bonds:

Location	Type *(stock, bond, etc.)*	Current Value

Life Insurance:

Do you have a whole life insurance policy? Yes_____ No_____
Approximate cash value: $_____ Face Value: $_____
Company Name: _____

Prepaid Burials:

Location: _____
Type: *(irrevocable, etc*.) _____
Date Purchased: _____
Cost: _____

LIABILITIES:

Mortgage Balance:

Name of Bank	Bank Address	Current Balance

Credit Card Balance:

Name of Credit Card Co.	Account Number	Current Balance

Other Loans:

Name of Loan	Account Type	Current Balance

SSI Payable:

Explanation of Payback	Current Balance

Other Liabilities:

Type of Liability	Current Balance

These assets and liabilities balances are as of _____(date).
Are there any assets or liabilities held jointly? Yes _____ No _____
If yes, explain:_____
_____

MONTHLY INCOME:

Social Security _____ $_____
Pensions (from) _____ $_____
Annuities (from) _____ $_____
Interest & Dividends (from) _____ $_____
S.S.I. (*copy of card*) _____ $_____
S.S.D.I._____ $_____
Other _____ $_____
Total Monthly Income: $_____

FUNERAL HOME:

Name: _____
Address: _____
Phone Number:_____
Director:_____

READINESS FOR PLACEMENT

The applicant is: (Please check yes or no for each question.)

A. In immediate need for placement. ❑ Yes ❑ No
B. Is presently in the hospital. ❑ Yes ❑ No
C. Is living in the community. ❑ Yes ❑ No
D. Is planning ahead for possible future needs. ❑ Yes ❑ No
E. Please provide a brief description of the applicant's medical needs and the reason for placement: _____

_____

Hospitals utilized during the past 2 years:

Name: _____ Address: _____ Dates: _____
Reason: _____

Name: _____ Address: _____ Dates: _____
Reason: _____

Nursing Home or Rehab Facility utilized within the LAST year:

Name: _____ Address: _____ Dates: _____
Reason: _____

Nursing Home Applicants, please fill in the information requested below. (Not applicable for Rest Home Applicants)

By definition, a patient in Massachusetts is considered private paying until their individual assets are spent down to the Massachusetts Medicaid Eligibility Limit of $2000.00. Anyone who has less than $2000.00, upon application, would be eligible to apply for Massachusetts Medicaid Assistance through the Massachusetts Department of Human Services (*Mass Health*), prior to admission. In order for our home to project the Private Pay and Medicaid Census, we request your assistance in completing the following questions.

Based on the above criteria, you would be: (please check one)

- ❑ Private Pay
- ❑ Already applied for Medicaid with decision pending.
- ❑ Not begun Medicaid application yet.
- ❑ A need to obtain further information regarding how to begin the decision process of Medicaid application.

Applicant/Preparer Signature: _____ Date: _____