100 Borden Street, Providence, RI 02903 (401) 454-7970

APPLICATION FOR ADMISSION

The following is an application for admission to our facility. Please complete this application and return it to the Business Office at your earliest convenience. Criteria for admission are the same for all persons without regard to race, religion, gender, national origin, age, physical or mental impairments.

Applicant Name____
(Please print) (Last) (First) (Middle)

Address____
(Street) (City, State, Zip Code)

Phone: Home/Cell/Work_________________________ Email address _____________________________

Date of Birth __________________________ Age _________ Gender________________

Marital Status: Married____ Divorced____ Widowed____ Single_____ Separated____

Spouse's Name ____

Primary Language _________________________________ U.S. Citizen? Yes_______ No __________

Current Living Situation: _____ Home ____ Family Members Home ______ Hospital

________ Nursing Home _____ Independent Living Facility _____ Assisted Living Facility

How long? ____________________________

Referred by: ____

Name of Facility/Residence if not own home____

Reason for Long Term Care Placement:

____

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Reason for Short Term Care Placement:

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RELATIVES OR SIGNIFICANT OTHERS

1st Person to be notified in an emergency:

Name ______________________________ Phone#: Home/Cell/Work________________________________

Address ____ Relationship_______________

Email Address ____

2nd Person to be notified in an emergency:

Name ______________________________ Phone#: Home/Cell/Work_______________________________

Address ____ Relationship______________

Email address ____

PHYSICIANS/HOSPITALIZATIONS

Primary Care Physician____

Address ____Phone_______________

Date of last visit____

Physician(s) consulted in past 2 years: (May list on separate sheet.)

1. Name ______________________ Address______________________________ Phone_______________

Specialty ____

2. Name ______________________ Address______________________________ Phone_______________

Specialty ____

Hospitals utilized during the past 2 years:

1. Name _______________________ Address________________________ Dates____________________

Reason ____

2. Name _______________________ Address________________________ Dates____________________

Reason ____

Nursing Home or Rehab Facility utilized within the prior twelve months:

Name ________________________ Address_________________________ Dates____________________

Reason ____

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FINANCIAL/BILLING INFORMATION

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

1. **Social Security #**________________________________

2. **Federal Medicare #** _____________________________

   Effective Dates: Part A_______________________ Part B______________________________

3. **State Medicaid #** _________________________________ Effective Date ____________________
4. **Medigap Plan C** # (or other supplemental insurance) ______________________________________
5. **Medicare Part D (**Pharmacy Plan) _____________________________ # _______________________
6. **Other Insurance** (such as Optum/Evercare) _____________________ # _______________________

Part I-Long Term Services and Supports (LTSS)/Medicaid in Skilled Nursing Facility (SNF)

By definition, a patient in Rhode Island is considered private paying until their individual assets are spent down to the R.I. Medicaid Eligibility Limit of $4,000.00. Anyone who has less than $4,000.00 upon application would be eligible to apply for R.I. Medicaid Assistance, through the R.I. Department of Human Services, Long Term Services & Support (LTSS) prior to admission. We will be better able to guide you by responding to the following:

Non-Skilled Payer Information-Based on the above criteria, the applicant would be: (Check one)

____Private Pay: If paying privately, at approximately $13,000 per month, the applicant predicts that they would remain private paying for approximately _______________________months.

> **Pharmacy Preference**: Please discuss with Admissions Office upon arrival. Unless otherwise noted, the House pharmacy will be used.

____Medicaid Eligible-LTSS/Nursing Home Medicaid assistance, the applicant:

______ has already applied with a decision of eligibility for SNF (not community).
______ has already applied with decision pending.***See below**
______ has not yet begun application process.
______ needs to obtain further information regarding how to begin the process to apply for LTSS/Medicaid for SNF.

***IF pending:** Case worker name________________________________ Phone: ________________
A copy of the completed application is required.

Part II

A. The applicant has Long Term Care (LTC) Insurance Yes No

B. If yes, with whom is the applicant insured? ____
(Name of Insurance Company) (Policy#)

A. If yes, please summarize the applicant's coverage by the LTC Policy. **We can assist with processing requests for reimbursement only**. This is not a form of payment.

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____
____

Powers of Attorney

Health Care Power of Attorney (Please provide copy on first day of admission.)

Name ______________________________ Address ____

Phone: Home/Cell/Work______________________________________ Relationship __________________

Email address ____

Financial Power of Attorney (Please provide copy on first day of admission.)

Name ______________________________ Address ____

Phone: Home/Cell/Work______________________________________ Relationship __________________

Email address ____

FINANCIAL RESPONSIBLE PARTY (individual responsible to forward payment of charges only)

Name ______________________________ Address ____

Phone: Home/Cell/Work______________________________________ Relationship __________________

Email address ____

CURRENT MONTHLY INCOME

Social Security $_________________________/mo. Stocks and Bonds $____________________/mo.

Pension $________________________________/mo. Income from Investments $_____________/mo.

Other-Specify Name: ______________________________ $____________________/mo.

CAPITAL ASSETS (including holdings jointly held)

Name of Banks ____

Checking Accounts-Current Balance $__________________________________ # of accounts: ___________

Savings Accounts-Current Balance $__________________________________ # of accounts: ___________

Life Insurance-Face value/Cash value $____

Real Estate (owned and/or mortgaged) $____

Investment Portfolio Value $______________________ as of date: ____________________

I fully understand that this is an application for the waiting list. I also understand a physical examination by the applicant's primary care physician is required before admittance to our facility. The examination is for medical evaluation and to insure proper placement for level of care.

Person completing application: _________________________________ ____________________________

(Please print) (Relationship to Patient)

Signature____ Date ____________________________

Office Use: Date Application Received _____________ Initials _____ Expected admit date __________

Current Status: ______ **Wait list applicant** _______ **Current Patient/Resident** (Financial review only)

Clinical Review: ________________ (Initials) _______________ (Date) Decision: _____approved _____denied

Financial Review: _______________ (Initials) _______________ (Date) Decision: _____approved _____denied