





\*All information supplied shall remain confidential. Application cannot be processed without this form.

Resident Name: \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Medicare #: \_\_\_\_\_  
 Medicare D#: \_\_\_\_\_  
 Medicaid #: \_\_\_\_\_ Pending as of: \_\_\_\_\_  
 MassHealth #: \_\_\_\_\_ Pending as of: \_\_\_\_\_  
 DSS Case Worker: \_\_\_\_\_ Phone #: \_\_\_\_\_  
 Other Medical Insurance: \_\_\_\_\_ Policy ID#: \_\_\_\_\_  
 Life Insurance Company: \_\_\_\_\_ Surrender Value: \$ \_\_\_\_\_  
 Does applicant own a partnership-approved long term care insurance policy? \_\_\_\_\_  
 Other long term care insurance: \_\_\_\_\_ Company: \_\_\_\_\_

### Current Monthly Income

Social Security: \$ \_\_\_\_\_ Where is this mailed? \_\_\_\_\_  
 Pension: \$ \_\_\_\_\_ Where is this mailed? \_\_\_\_\_  
 VA Benefits: \$ \_\_\_\_\_ Where is this mailed? \_\_\_\_\_  
 SSI: \$ \_\_\_\_\_ Where is this mailed? \_\_\_\_\_  
 CDs: \$ \_\_\_\_\_ IRAs: \$ \_\_\_\_\_  
 Annuities: \$ \_\_\_\_\_ Dividends: \$ \_\_\_\_\_  
 Other Income: \$ \_\_\_\_\_

Does Applicant have a Trust:  yes  no If yes, explain: \_\_\_\_\_

Cash Asset	Bank	Account #	Type	Amount

Current Non Liquid Assets: \$ \_\_\_\_\_

### Real Estate

Does the applicant own any property?  yes  no  
 Type & location: \_\_\_\_\_  
 Names on deed: \_\_\_\_\_  
 Estimated value: \$ \_\_\_\_\_ Payable on mortgage: \$ \_\_\_\_\_  
 Has there been any sale or transfer of property/assets (liquid/non-liquid) within the past 60 months?  yes  no  
 If yes, please specify amount & to whom: \_\_\_\_\_  
 Was applicant and/or spouse a member of the US Armed Forces?  yes  no Branch: \_\_\_\_\_  
 Where has the applicant been within the past 60 days: \_\_\_\_\_

If applicant is unable to handle their financial affairs, to whom can outstanding bills be sent for payment?  
 Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Relationship to applicant: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Person Completing Application Date



Resident Name: \_\_\_\_\_  
 Current Physician \_\_\_\_\_ Will physician be following?  yes  no  
 Current Diagnosis \_\_\_\_\_  
 Past Medical History \_\_\_\_\_  
 Medications \_\_\_\_\_

### Nursing Needs

Indicate all that apply

Ambulation	Continenence	Feeding	Bathing
<input type="checkbox"/> Independent	<input type="checkbox"/> Continent	<input type="checkbox"/> Independent	<input type="checkbox"/> Independent
<input type="checkbox"/> With Assist	<input type="checkbox"/> Incontinent	<input type="checkbox"/> With Assist	<input type="checkbox"/> With Assist
<input type="checkbox"/> Walker	<input type="checkbox"/> Bowel	<input type="checkbox"/> Total Assist	<input type="checkbox"/> Total Care
<input type="checkbox"/> Cane	<input type="checkbox"/> Bladder	<input type="checkbox"/> Feeding Tube	
<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Foley Catheter	<input type="checkbox"/> NG	<b>Dressing</b>
<input type="checkbox"/> Bedbound	<input type="checkbox"/> Texas Catheter	<input type="checkbox"/> Gastric	<input type="checkbox"/> Independent
<input type="checkbox"/> Transfers	<input type="checkbox"/> Sup. Pub. Cath.	<input type="checkbox"/> J-tube	<input type="checkbox"/> With Assist
<input type="checkbox"/> Ind.	<input type="checkbox"/> Ostomy (type) _____	<input type="checkbox"/> Rate	<input type="checkbox"/> Total Care
<input type="checkbox"/> Assist of		<input type="checkbox"/> Solution	
<input type="checkbox"/> 1 <input type="checkbox"/> 2		<input type="checkbox"/> Special Diet _____	

Adaptive Equipment: (type) \_\_\_\_\_

Mental Status	Behavior	Miscellaneous
<input type="checkbox"/> Alert	<input type="checkbox"/> Cooperative	Weight _____
<input type="checkbox"/> Understands	<input type="checkbox"/> Depressed	Height _____
<input type="checkbox"/> Forgetful	<input type="checkbox"/> Withdrawn	<input type="checkbox"/> Hearing Impaired _____
<input type="checkbox"/> Confused	<input type="checkbox"/> Belligerent	<input type="checkbox"/> Speech Impaired _____
<input type="checkbox"/> Non Responsive	<input type="checkbox"/> Noisy	<input type="checkbox"/> Vision Impaired _____
<input type="checkbox"/> Oriented	<input type="checkbox"/> Needs Restraints	<input type="checkbox"/> Dentures _____
<input type="checkbox"/> Disoriented	<input type="checkbox"/> Wanders	<input type="checkbox"/> Allergies _____
	<input type="checkbox"/> Combative	<input type="checkbox"/> Skin:
		<input type="checkbox"/> Intact _____
		<input type="checkbox"/> Reddened _____
		<input type="checkbox"/> Open Area _____
		<input type="checkbox"/> Size _____
Therapies Received: _____		<input type="checkbox"/> Oxygen _____
Therapies Needed: <input type="checkbox"/> P.T. <input type="checkbox"/> O.T <input type="checkbox"/> Speech		

Treatments: \_\_\_\_\_

Other Pertinent Medical Information: \_\_\_\_\_