HALE BARNARD CORPORATION

273 Clarendon Street
Boston, MA 02116

617-536-3726

Application for Admission

All applications will be confidential.

Applications will be considered once they are complete. Decision on admission will not be made until medical information is reviewed and reference checks are completed.

Hale House Executive Director
Tracey Cravedi

Admissions Application

Date: _____
SS #: _____

A. Introductory Information

1. Name: _____

2. Present address: _____
_____
_____

How long at this address? _____

3. Telephone #: _____

4. Previous address: _____
_____
_____

5. Date of Birth: _____

6. Birthplace: _____
_____
_____

Maiden Name: _____

7. Current Marital Status:

Married ____ Single ____ Widowed ____ Divorced ____ Separated ____

8. Father's Full Name: _____

9. Mother's Full Name: _____

10. Number of Children: _____

Name	Address	Home Tel #	Work Tel #

(Continued)

11. References that we may call (other than family):

Name	Address	Home Tel #	Work Tel #

12. U. S. Citizen? Yes: _____ No: _____ Certificate No.: _____

B. Background Information

1. Education:

_____
High School

_____
Other

2. Occupations: _____

_____

_____

When last employed: _____

3. Membership in organizations: _____

_____

4. Recreational interests and hobbies: _____

_____

5. Religious affiliation: _____

_____

6. Cemetery: _____

Deed held by: _____

Burial insurance: _____

Funeral director: _____

(Continued)

C. Medical Information

1. Name of your physician(s): _____

   _____

2. Date of your last treatment or examination: _____

3. List hospitalization(s) within the last ten years:

4. Who is your agent for your Health Care Proxy?_____

5. Have you ever been a resident of another retirement or nursing home?

Name	*Dates*

D. Hospital and medical benefit coverage

1. Do you have any coverage for hospital and medical expenses?

   Yes _____ No _____

   Medicare ID.: _____

   Medex ID.: _____

   Medicaid ID.: _____

   Other medical coverage: _____
   Name of company Policy No.

(Continued)

Declaration of Finances

E. Confidential Financial Information

About the Confidential Financial Statement

You are asked to complete the following financial section of this application. Should you at any time have questions or concerns, please contact the Administrator. This statement must be updated at the time of admission and periodically thereafter, when requested to do so.

Individual responsible for paying bill

Name: _____ Relationship to resident: _____

Home address: _____ City: _____

State: _____ Zip: _____ Driver's License #: _____

Telephone: _____ _____
Home Business

Email: _____

F. Assets

Real Property:

Real Estate Location	Net Value (current value less mortgage balance)	Held Jointly?
_____	_____	_____
_____	_____	_____

Total Real Estate Value: _____

Bank Accounts:

Name of Bank, Credit Unions, etc.	Account Type	Current Balance	Estimated Annual Income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Investment Account:

(Continued)

Location	Type (mutual fund, Stocks, etc.)	Current Balance	Estimated Annual Income
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

G. Life Insurance:

Does resident have life insurance policies with cash value? Yes _____ No _____
Approximate cash value $ _____ Annuities $_____
Company name _____

1. Monthly Income

Social Security	$_____
Pensions	$_____
Annuities	$_____
Interest & Dividends	$_____
S.S.I.	$_____
S.S.D.I.	$_____
S.S.P.	$_____
Other	$_____
Indicate source	
Total Monthly Income (*)	**$_____**

2. Assets

Savings	$_____
Bonds	$_____
Stocks/ Investments	$_____
Annuities	$_____
Real Estate	$_____
Mortgage Bal.	$_____
Life Insurance (Indicate full amount i.e. amount payable to others upon your death)	$_____
Total Assets	**$_____**

(*) We request income tax returns for the three most recent years.

(Continued)

3. Are any of the above assets held jointly? _____YES _____NO

   If yes, please explain: _____

   _____

4. Are there any obligations against, or restrictions on any of these assets?
   _____YES _____NO

   If yes, please explain: _____

   _____

5. Are any of these assets held in trust? _____YES _____NO

   If yes, please explain: _____

   _____

6. If yes, Trust Officer's Name and address: _____

   _____

7. Have you made substantial gifts or transfers to any person, persons, or organizations in any of the previous three (3) years? _____YES _____NO

   If yes, please describe in space below.

Declaration of Finances

H. Annual Expenses:

Health/medical insurance	$_____
Prescriptions	$_____
Federal and state taxes	$_____
Estimated personal expenses (e.g., clothes, gifts, subscriptions, memberships, outings, personal grooming, credit cards, etc.)	$_____
Automobile expenses (e.g., maintenance, insurance, registration, etc.)	$_____
Other	$_____

Is it your belief that your income and assets (remaining after payment of Entry Fee) will be adequate to meet your Monthly Fee to the Home and your other living expenses during your residence at the Home? _____ Yes _____ No

If no, please explain: _____

_____

_____

_____

I verify that I have listed all assets in excess of $200. (Two Hundred Dollars).

These statements are true to the best of my/our knowledge and belief. I/we agree that I/we will not make substantial gifts or transfer assets of surplus income so that any remaining assets are insufficient to meet my/our financial obligation to the Home.

Signature: _____ Date: _____
(Applicant)

Signature: _____ Date: _____
(Person listed in Section E of Declaration of Finances)

Supporting documentation of assets and liabilities listed must accompany this application.

(Continued)

Date: _____

Admission Physical

Name: _____ Date of Birth: _____

Current Address: _____
(Street, City, State, Zip)

Physician: _____
Date of last physical exam: _____
Primary Medical Diagnosis: _____
Secondary Diagnosis(es): _____
_____
Other Physicians:
_____
_____

Dates of: TB test (PPD)_____ RESULTS_____ Pneumovax_____ TD (q 10 yrs) _____

Vital Signs/Allergies

Height: _____ Weight: _____ BP: _____ T.: _____ P.: _____ R.: _____
Diet: _____ Restrictions: _____
Allergies: Y / N Food: _____ Medications: _____ Other: _____
If yes, please explain further: _____
_____
_____

Medications

_____
_____
_____
_____
_____

Medical History

Heart Circulation		Neurological		Other	
Arteriosclerotic heart disease	_____	Alzheimer's	_____	Anemia	_____
Cardiac dysrhythmias	_____	Dementia	_____	Arthritis	_____
Heart Failure	_____	Aphasia	_____	Cancer	_____
Hypertension	_____	Memory Deficit	_____	Osteoporosis	_____
Hypotension/Syncope	_____	Multiple Sclerosis	_____	Seizure disorder	_____
Peripheral vascular disease	_____	Parkinson's	_____	Thyroid disorder	_____
Other cardiovascular disease	_____			Urinary tract	_____
Pacemaker	_____				

Pulmonary		Sensory		Psychiatric	
Emphysema/Asthma/COPD	_____	Cataracts	_____	Anxiety disorder	_____
Pneumonia	_____	Glaucoma	_____	Depression	_____
Pneumocystosis	_____	Macular	_____	Manic Depressive	_____
		Degeneration	_____	Panic disorder	_____
		Neuropathy	_____	Schizophrenia	_____
				Paranoia	_____
				Paranoid/Schizophrenia	_____

(Continued)

Admission Physical

Hospitalizations/Operations/Injuries:

Date	Description
_____	_____
_____	_____
_____	_____
_____	_____

Illnesses requiring attention by a physician in the past year:

_____

Specific treatments and frequency:

_____

Special equipment or therapy (*PT, OT, speech – please indicate if resident is currently receiving and should continue)*: _____

_____

Has resident ever been treated for a nervous or mental disorder?
If yes, where and when? _____

_____

Is the resident oriented to time, place, person? Yes _____ No _____
If no, please explain. _____

_____

Is the resident, in your opinion, able to perform the activities of daily living listed below: (Check if applicable)

Dressing/grooming: _____ Ambulation: _____ Bathing: _____
Eating: _____ Toileting: _____

Is resident incontinent at times? (Yes / No) BM: _____ Urine: _____
Frequency: _____

Have you discussed advanced directives or DNR with resident? Yes _____ No _____

What is the status of this discussion? _____

Is resident medically and socially appropriate for Level IV care?

Physician's Signature: _____
Date: _____

(Continued)

273 Clarendon Street, Boston, MA 02116
Phone: 617-536-3726 Fax: 617-536-7480

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: **Hale Barnard Corporation**

Address: **273 Clarendon Street**

City: **Boston** State: **MA** Zip Code: **02116**

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, Chlamydia, non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereuem, HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome), and gonorrhea.

☐ Yes ☐ No I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

(Continued)

I, _____, or my legal representative, _____, hereby state that to the best of my ability I have no knowledge that _____ owes no back monies, no repayment or overpayments nor in any other way is encumbered by the Social Security Administration, Veterans Administration, state of Massachusetts Public Welfare Agency, nor any other public agency that might be involved in helping me pay my rent at Hale House, either now or in the future.

Name:_____

Signature:_____

Date: _____

Name of Conservator, Rep. Payee or
any other Legal Representative: _____

Signature: _____

Date: _____