Country
Center for Health & Rehabilitation

APPLICATION FOR ADMISSION

You have contacted this nursing home and indicated a desire to be admitted as a resident to this facility.

Please find enclosed this facility's written application form. As soon as you substantially complete and return the form to the facility, your name will be placed on our waiting list for admission to the facility. Your name will only be placed on our waiting list after you substantially complete and return this written application form to us.

180 Low Street, Newburyport, MA 01950 • Phone: 978.465.5361 • Fax: 978.463.9366

PERSONAL INFORMATION

Applicant's Name _____

Home/Previous Address _____

Present Location/Address _____

If a medical facility, date of admission

Date of Birth _____ Age _____ Birthplace _____ Religion _____

Marital Status _____Previous Occupation _____Education _____

Hobbies/Interests (Past & Present)_____Veteran (spouse of) Yes _____No _____

_____Veteran Service # _____

_____Branch of Service _____

Primary Contact Person _____Relationship_____

Address: _____

Telephone: Days _____ Evenings_____

POA _____ Conservator: Person _____ Estate_____ (Please include documentation)

Other Involved Parties

Name _____Relationship_____

Address: _____

Telephone: Days _____ Evenings_____

Name _____Relationship_____

Address: _____

Telephone: Days _____ Evenings_____

MEDICAL INFORMATION

Name/address of current physician _____

_____Phone #_____

Names/addresses of all previous physicians and hospitalizations (and dates hospitalized)

_____

_____

_____

Is applicant receiving community services? If so, please list agencies & contact person.

_____

_____

Reason placement is needed _____

Attitude towards placement: Applicant _____Family _____

Anticipated length of stay _____

Diagnosis _____

Medications_____

What assistance does applicant require with personal care (i.e. dressing, eating, walking, etc.)?

_____

_____

Please list mental limitations or behavioral difficulties and successful management techniques.

_____

_____

FINANCIAL INFORMATION

Social Security # _____Medicare # _____ Part A_____

Part B_____

Medicaid (State Assistance) # _____

Does applicant have an application pending for State Medical Assistance (Title 19)?_____

If yes, date application submitted _____District Office _____Caseworker_____

Other Medical/Hospital Insurance:

Name of Company	Subscriber/Group #	Type of Insurance
_____	_____	_____
_____	_____	_____
_____	_____	_____

Life Insurance. (List only policies having a cash surrender value and give approximate cash surrender value): _____

_____

Has applicant established an irrevocable burial account? _____

If so, name of funeral home and amount _____

INCOME

Social Security	$ _____/Mo.	
Pensions	$ _____/Mo.	Source _____
VA Benefits	$ _____/Mo.	
Annunities	$ _____/Mo.	Source _____
Interest	$ _____/Mo.	Source _____
Dividends	$ _____/Mo.	Source _____
Other	$ _____/Mo.	Source _____

Do you receive income from or have any interest in any trust? _____

If yes, please describe and provide a copy of the trust instrument.

_____

_____

ASSETS (If any asset is jointly held, please give name of joint owner).

Real Estate

Does applicant own any real estate? Yes _____ No _____

Description of Property	Approximate Value	Name(s) on Deed
_____	_____	_____
_____	_____	_____

Are there any liens or mortgages against the property? Yes _____ No_____

If yes, in the amount of $ _____ payable to _____

Was this real estate your home prior to entering the nursing home? Yes _____ No_____

Is your spouse now living in the home? Yes _____ No_____

Do you have a “life use” of any real estate (any ownership interest, in full or in part, for your lifetime, or the right to occupy property for your lifetime)? Yes _____ No_____

If yes, please describe _____

_____

_____

Cash Assets

Please list all assets including but not limited to: Savings Accounts, Checking Accounts, Stocks, Bonds, C.D.'s

Name of Institution	Account #	Present Balance
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Transfer of Assets

Within sixty (60) months prior to the date of this application, have you given away assets of any kind (cash, securities, real estate, etc.) or transferred assets of any kind (cash, securities, real estate, etc.) for less than fair market value? If so, please describe fully all such gifts or transfers in excess of $1000, including the asset transferred, names, addresses and relationship to you of the person to whom the gift or transfer was made, and the value of the gift or transfer.

Gifts or transfers within 60 months: Yes _____ No_____

Please describe _____

_____

_____

_____

Within sixty (60) months prior to the date of this application, have you created any trusts or placed funds or any other assets in a trust that already existed?

Yes _____ No_____ If yes, please describe and provide a copy of the trust instrument.

_____

_____

I hereby certify that this is a true and complete statement of the applicant's current income and assets and any gifts or transfers for less than fair market value in excess of $1,000 and any trusts created or transfers of assets to any trust that they have made within the sixty (60) months prior to the date of this application.

_____

(Applicant)

_____

(Responsible Party)

_____

(Date)

(PLEASE RETURN WITH APPLICATION)

Country
Center for Health & Rehabilitation

TO: APPLICANTS FOR ADMISSION AND THEIR FAMILIES

Country Center for Health & Rehabilitation has a provider agreement with the State of Massachusetts to provide services to Medicaid recipients pursuant to Title XIX of the Social Security Act, and to provide services to Medicare recipients pursuant to Title XVIII of the Social Security Act.

State and federal law and regulations impose the following limitations on the advance payment and deposit requirements of nursing homes:

- No nursing home may request an advance payment or deposit from a Medicare beneficiary for any services or supplies covered by Medicare as a condition of admission.
- A nursing home may request an advance payment or deposit of up to one thousand five hundred dollars ($1,500.00) from an applicant who has applied for Medicaid, provided such payment or deposit is held in an account for the applicant's benefit and returned to the applicant when he is determined eligible for Medicaid.
- No nursing home may request an advance payment or deposit from a Medicaid recipient as a condition of admission.
- Upon admission, **Country Center for Health & Rehabilitation** requires self-pay residents or their responsible party, to pay the facility an advanced room and board payment equal to thirty (30) days at the current self pay per diem rate.

Public Act 91-8 (9/4/91) provides that nursing facilities with a census of 30% or less of private pay residents shall not be required to admit an indigent person on a waiting list during the subsequent six (6) months, provided that no bed be held open for more than (30) thirty days.

In compliance with State and Federal laws, **Country Center for Health & Rehabilitation** admits and treats all residents equally, regardless of race, color, sex, national origin, or source of payment.

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(PLEASE RETURN WITH APPLICATION)

I acknowledge that I have received a copy of this statement. The facility has explained the information in the statement to me, and I am signing this statement to show that I understand it.

_____ _____

Name of Resident **Signature of Resident**

-OR-

_____ _____

Name of Representative **Signature of Representative Party***

_____

Date

*If a representative party is signing this form on behalf of the resident, indicate below his or her relationship to the resident.

_____

THIS NOTICE MUST BE SIGNED AND RETURNED TO US BEFORE WE CAN ADMIT ANY RESIDENT.