

Dodge Park Rest Home  
101 Randolph Road  
Worcester, MA 01606  
Telephone: (508) 853-8180  
Fax: (508) 853-4545

**APPLICATION FOR ADMISSION**

Thank you for your interest in Dodge Park Rest Home. In order to be considered for residency, please complete this application in full. The information requested will help us assess your ability to live in our Rest Home. Please do not hesitate to call us if you need assistance completing this form.

**I. General Information**

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone No.: \_\_\_\_\_

Sex: Male \_\_\_\_ Female \_\_\_\_

Social Security No.: \_\_\_\_\_

Medicare No.: \_\_\_\_\_ Medicaid No.: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Birth Place: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Former Occupation: \_\_\_\_\_

Do you plan on bringing an automobile to Dodge Park Rest Home? Yes \_\_\_\_ No \_\_\_\_

**II. Responsible Person**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Telephone (H): \_\_\_\_\_ Telephone (W): \_\_\_\_\_

Is there a Health Care Proxy? \_\_\_\_\_ (If yes, please provide copy)

Is there a Power of Attorney? \_\_\_\_\_ (If yes, please provide copy)

**III. Housing**

Do you live alone? Yes \_\_\_\_\_ No \_\_\_\_\_ If no, with whom do you live? \_\_\_\_\_

Is there any special support or assistance you will need? \_\_\_\_\_

Are you considering other housing alternatives? Is so, what? \_\_\_\_\_

**IV. Medical Information/Preliminary Service Plan**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_

Will Physician attend here? Yes \_\_\_\_\_ No \_\_\_\_\_

Physician's Hospital Affiliation (if any): \_\_\_\_\_

How would you describe your present state of health? \_\_\_\_\_

Do you have a health condition that requires regular, daily attention or monitoring? (e.g. on oxygen, insulin dependent diabetes, blood pressure, skin condition) Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, for what? \_\_\_\_\_

Who monitors it now? \_\_\_\_\_

Do you see a medical specialist? Yes \_\_\_\_\_ No \_\_\_\_\_ Why? \_\_\_\_\_

Name: \_\_\_\_\_ Specialty: \_\_\_\_\_

Do you have medical insurance? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of Medical Insurer(s): \_\_\_\_\_

Address: \_\_\_\_\_

Policy Number(s): \_\_\_\_\_

Are you on medication at the present time? Yes \_\_\_\_\_ No \_\_\_\_\_

Please list medications: \_\_\_\_\_

Do you need assistance with medications? Yes \_\_\_\_\_ No \_\_\_\_\_

Are you on a special diet? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Allergies: \_\_\_\_\_

How much walking do you do? \_\_\_\_\_

Do you have difficulty with stairs? Yes \_\_\_\_\_ No \_\_\_\_\_

Is incontinence a problem? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, how often? Occasionally \_\_\_\_\_ Regularly \_\_\_\_\_

How do you care for you incontinence? Independent \_\_\_\_\_ Need Assistance \_\_\_\_\_

It would be helpful to us in evaluating your needs to have you rate your skills in the following areas:

I = Independent

M = Moderate Assist

T = Total Assist

	Rating	Comments
Bathing	_____	_____
Dressing	_____	_____
Walking	_____	_____
Housekeeping	_____	_____
Laundry	_____	_____
Budgeting	_____	_____
Shopping	_____	_____
Transportation	_____	_____
Fire Awareness	_____	_____

**V. Mental Status/Behavior of Applicant**

Alert \_\_\_\_\_ Appropriate \_\_\_\_\_ Cooperative \_\_\_\_\_ Oriented \_\_\_\_\_  
Confused \_\_\_\_\_ Wanders \_\_\_\_\_ Combative \_\_\_\_\_ Disoriented \_\_\_\_\_

**VI. Financial Information**  
**(Attach additional sheets if more space is needed)**

A. Cash assets in banks, credit unions, and savings and financial institutions

1. Institution Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Type of Account: \_\_\_\_\_ Balance in Account: \$ \_\_\_\_\_  
Names listed on Account: \_\_\_\_\_
2. Institution Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Type of Account: \_\_\_\_\_ Balance in Account: \$ \_\_\_\_\_  
Names listed on Account: \_\_\_\_\_
3. Institution Name: \_\_\_\_\_ Address: \_\_\_\_\_  
Type of Account: \_\_\_\_\_ Balance in Account: \$ \_\_\_\_\_  
Names listed on Account: \_\_\_\_\_

B. Other liquid assets/investments (stocks, bonds, IRA's, annuities)

1. Type of Investment: \_\_\_\_\_ Company Name: \_\_\_\_\_  
Names on Account: \_\_\_\_\_ Approximate Value: \$ \_\_\_\_\_
2. Type of Investment: \_\_\_\_\_ Company Name: \_\_\_\_\_  
Names on Account: \_\_\_\_\_ Approximate Value: \$ \_\_\_\_\_
3. Type of Investment: \_\_\_\_\_ Company Name: \_\_\_\_\_  
Names on Account: \_\_\_\_\_ Approximate Value: \$ \_\_\_\_\_
4. Type of Investment: \_\_\_\_\_ Company Name: \_\_\_\_\_  
Names on Account: \_\_\_\_\_ Approximate Value: \$ \_\_\_\_\_

C. Real estate assets

Does the Applicant own his/her home? Yes \_\_\_\_\_ No \_\_\_\_\_

Address: \_\_\_\_\_

Approximate Value \$ \_\_\_\_\_

Mortgages and Liens – List Each Separately

Creditor: \_\_\_\_\_

Amount: \$ \_\_\_\_\_ Monthly Payment: \$ \_\_\_\_\_

Creditor: \_\_\_\_\_

Amount: \$ \_\_\_\_\_ Monthly Payment: \$ \_\_\_\_\_

Is the property owned jointly? Yes \_\_\_\_\_ No \_\_\_\_\_

Name(s) of co-Owner(s): \_\_\_\_\_

Does the Applicant own any additional property? Yes \_\_\_\_\_ No \_\_\_\_\_

Address: \_\_\_\_\_

Approximate Value \$ \_\_\_\_\_

Mortgages and Liens – List Each Separately

Creditor: \_\_\_\_\_

Amount: \$ \_\_\_\_\_ Monthly Payment: \$ \_\_\_\_\_

Creditor: \_\_\_\_\_

Amount: \$ \_\_\_\_\_ Monthly Payment: \$ \_\_\_\_\_

Is the property owned jointly? Yes \_\_\_\_\_ No \_\_\_\_\_

Name(s) of co-Owner(s): \_\_\_\_\_

D. Does the Applicant have life insurance policies with cash value? Yes \_\_\_\_\_ No \_\_\_\_\_

Company Name: \_\_\_\_\_

Approximate Cash Value \$ \_\_\_\_\_

E. Is the Applicant a beneficiary of a Trust? Yes \_\_\_\_\_ No \_\_\_\_\_

Trust Name: \_\_\_\_\_

Approximate Value: \$ \_\_\_\_\_

Describe Applicant's Beneficial Interest: \_\_\_\_\_

\_\_\_\_\_

F. Monthly Income	Monthly Amount
Social Security	\$ _____
Pensions (describe)	
_____	\$ _____
_____	\$ _____
_____	\$ _____

Rental Income (describe)

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

Annuities \$ \_\_\_\_\_

Trust Income \$ \_\_\_\_\_

Other (describe)

\_\_\_\_\_ \$ \_\_\_\_\_

G. Does the Applicant have long term care insurance? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, describe the benefits provided: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

H. Does the Applicant have any Liabilities? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

\_\_\_\_\_ \$ \_\_\_\_\_

Does someone other than you administer your finances? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

I hereby certify that to the best of my knowledge and belief, the above stated information is true, correct and complete. I understand that if any information has been falsely represented or any material omissions made, such misrepresentation or omission would constitute sufficient cause for voiding my application for admission and may be a basis for liability for any unpaid charges to Dodge Park Rest Home. All of the information will be kept confidential by Dodge Park Rest Home.

I understand and agree that the foregoing application is not a contract or reservation for residence. Nothing contained herein is binding on either party until an Admission Agreement has been signed by the parties hereto.

Signature of Applicant \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Responsible Party \_\_\_\_\_ Date: \_\_\_\_\_

Dodge Park Rest Home complies with the provisions of Title VII of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975, and all agreements imposed pursuant thereto to the end that no person shall be eliminated from participation and/or denied benefits or otherwise be subject to discrimination on the basis of race, creed, color, national origin, disability, age, or veteran status in the provision of care or service for residents or in employment practices.

DODGE PARK REST HOME - DO NOT COPY