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

APPLICATION FOR ADMISSION

(Please Type or Print Clearly)

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 and Financial Information

A.1 Applicant's Name: _____

Address: _____

Telephone No.:_____

Sex: Male ____ Female ____

Social Security No.: _____

Date of Birth: _____ Birth Place: _____

Marital Status: _____ (If married please fill out section A.2.)

Former Occupation: _____

Are You A Veteran: [] Yes [] No (If yes – you may be qualified to VA assist)

Is Your Spouse A Veteran [] Yes [] No

If you have a deceased spouse, was he or she a veteran? [] Yes[] No

A.2 Your Spouse's Name _____ Work Phone: _____

Street Address _____ Fax # _____

City/State/Zip _____ Home Phone: _____

Occupation _____ Cell Phone: _____

Work/Personal Email: _____

A.3 **Health Insurance**

	Policy Name	Premium
Medicare		
Medicare Advantage Plan (HMO)		
Mass Health		
Medigap (i.e. Medex)		
Medicare Prescription Drug Plan		
Dental Plan		
Long Term Care*		
Others		

- *If you have a long term care insurance policy, please provide us with a copy of the* policy

A.4. **Trust, Funeral and Vehicle**

1. Are either you or your spouse the grantor or beneficiary of a trust? [] Yes [] NO

A "grantor" is the person who set up the trust. A "beneficiary" is someone who can receive money from the trust.

If yes, please make the trust document available for review.

2. Do you have a pre-paid funeral? [] Yes [] NO

If yes, please make the pre-paid funeral document available for review.

3. Please list any vehicle you own including cars, vans, recreational vehicles, mobile home and boats:

Make/Year	Name Of Owner	Equity
1.		

2.		
3.		

A.5. Do either you or your spouse have a **life insurance** policy? If yes, please complete below. If there are more than three (3) policies, continue on a separate sheet.

	Policy # 1	Policy # 2	Policy # 3
Owner Of Policy			
Insurance Company			
Face Value			
Cash Surrender Value			
Insured (Full Name)			
Beneficiary (s)			
Successor Beneficiary (s)			
Other			

A.6. Please list any **retirement account you own, such as IRAs, 401(k), or 403(b) accounts, SEP plans**, etc.

Bank, Mutual Fund, etc	**Account #**	**Owner**	**Beneficiary**	**Successor Beneficiary**	**Amount**

A.7 Please list any **securities, stocks, bonds** other than retirement accounts (including US savings bonds), money market funds (in an investment house), etc? If investment is held by brokerage house, it is sufficient to list account and total value (not individual holdings)

Name of Security	**Name (s) In Which Security Is Held**	**Value**

A.8. Please list each **bank account** other than retirement accounts (Including certificate of deposit, money market accounts, and checking accounts), owned by you or on which your name appears. For married couple we will need all accounts held by either you and/or your spouse.

Bank Name	**Account #**	**Name(s) In Which Account IS Held**	**Amount**

A.9 Have you made **gifts** of any money or property in the past 5 years? If so please list the date, value and to whom it was given.

Date	Value of Gift	Person Receiving Gift

A.10 Please describe your **regular monthly income** (do not list income from investment) and, if applicable, your spouse income. If the income is directly deposit to a bank account, please indicate so. If you have more than one rental income, please provide the rental properties information as well on a separate sheet.

Current Income	Husband	Wife	Joint	Bank
Salary,Wages				
Social Security / SSI				
Annuities				
Pension				
Trust				
Rental (Net)				
Business/Other				

Does someone other than you administer your finances? Yes _____ No _____

If yes, Name: _____ Relationship: _____

Address: _____ Telephone: _____

A.11 **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): _____

Was any real estate transfer to another entity (children, spouse, trust) in the past 60 months:

[] YES [] NO If yes Please specify:

Date of transfer: _____ To Whom: _____

Relationship: _____

II. Responsible Person and Childrens

(Please Type or Print Clearly)

Name: _____ Relationship: _____

Address: _____ City: _____ State: ____ Zip: _____

Telephone (H): _____ Telephone (W): _____

Work E:mail: _____ Personal E:mail:_____

Additional E:mail: _____

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

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

Please provide us with information about your **children**. Please include **full legal names including middle initials**

Child # 1 Name		Primary email address	
Street Address		Child of this marriage?	[] Yes [] No
City/State/Zip		Adopted?	[] Yes [] No
Work Phone #		Disabled?	[] Yes [] No
Home Phone #		POA?	[] Yes [] No
Cell Phone #		Health Care Advance Directive	[] Yes [] No
Fax #		Occupation	

Child # 2 Name		Primary email address	
Street Address		Child of this marriage?	[] Yes [] No
City/State/Zip		Adopted?	[] Yes [] No
Work Phone #		Disabled?	[] Yes [] No
Home Phone #		POA?	[] Yes [] No
Cell Phone #		Health Care Advance Directive	[] Yes [] No
Fax #		Occupation	Fax #

Child # 3 Name		Primary email address	
Street Address		Child of this marriage?	[] Yes [] No
City/State/Zip		Adopted?	[] Yes [] No
Work Phone #		Disabled?	[] Yes [] No
Home Phone #		POA?	[] Yes [] No
Cell Phone #		Health Care Advance Directive	[] Yes [] No
Fax #		Occupation	Fax #

III. Medical Information/Preliminary Service Plan

(Please Type or Print Clearly)

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: _____

Are you on medication at the present time? Yes _____ No _____

Please list medications including over the counter, vitamin, etc:

Medication Name	Doze	Direction	Prescribing Physician	Start Date

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	_____	_____

IV. Mental Status/Behavior of Applicant

(Please Type or Print Clearly)

Alert _____	Appropriate _____	Cooperative _____	Oriented _____
Confused _____	Wanders _____	Combative _____	Disoriented _____

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.