BALLOU HOME FOR THE AGED

60 Mendon Road
Woonsocket, RI 02895-1512
Telephone (401) 769-0437
Facsimile (401) 769-7481

APPLICATION FOR ADMISSION

The following is an application for admission to our facility. Please complete this application and return it to the facility. Criteria for admission are the same for all people without regard to race, gender, national origin, age, physical or mental impairments or financial resources**.**

PLEASE COMPLETE THE FOLLOWING:

Name:_____
Last **First** **Middle**

Social Security Number _____

Present Address _____ Phone( )_____

Permanent Address _____ Phone ( ) _____

Date of Birth _____Age _____ Place of Birth_____
Marital Status M _____D ____W ____S ___Sep. _____

Spouse's Name _____ Spouse's Date of Birth _____

Religion _____ Place of Worship _____

Address_____
Burial Plan: Yes No Funeral Director_____

Lifetime Occupation _____ Education _____

Primary Language _____ US Citizen? Yes ___No_____

Recommended by _____

Readiness for Placement
The applicant is (Please circle yes or no)

A. In immediate need for placement Yes No

B. Is presently in hospital Yes No

C. Is living in the community Yes No

D. Is planning ahead for possible future needs Yes No

E. Please provide a brief description of the applicant's medical needs and the reason for placement _____
_____
_____

Relative or Significant Others

Person to be notified in an emergency:

(First)
Name _____ Phone # (H)_____(W)_____
Address _____ Relationship_____

(Second)
Name _____ Phone # (H)_____(W)_____
Address_____Relationship_____

Physicians/Hospitalizations

Primary
Care_____Address_____Phone_____
Date of last visit_____ Will physician follow to Nursing home? Yes No

Physicians consulted in past 2 years:
Name_____Address_____Phone_____
Speciality_____

Name_____Address_____Phone_____
Speciality_____

Hospitals utilized during the past 2 years:
Name_____ Address _____Dates_____
Reason_____

Name_____ Address _____Dates_____
Reason_____

Nursing Home or Rehab Facility utilized within the **LAST** year:

Name_____Address_____Dates_____
Reason_____

Financial/Billing Information

Health Insurance **(Please provide copies of all medical cards)**

Social Security# _____ Federal Medicare_____

State Medicaid _____ Effective Date_____

Other Insurance_____

Policy #_____

Medicare D Plan_____

PART I

By definition, a patient in Rhode Island is considered private paying until their individual assets are spent down to the RI Medicaid Eligibility Limit of **$4,000.00**. Anyone who has less than **$4,000.00**, upon application, would be eligible to apply for RI Medicaid Assistance through the RI Department of Human Services, prior to the resident's admission. Your assistance is requested in completing the following questions.

The applicant would be **(Please circle one)**

Private Pay or Medicaid Eligible

A. If paying privately, at the daily rate of $_____, the applicant predicts that they would remain private paying for approximately (length of time, months, or years):_____

B. If there is a need for Medicaid Long Term Care Assistance, the applicant has:

_____Already applied with a decision of eligibility
_____Already applied with a decision pending
_____Not begun application yet
_____A need to obtain further information regarding how to begin the decision process of Medicaid application

PART II

A. The applicant has Long Term Care Insurance Yes No
B. If yes, the applicant's insurer? _____
Name of Insurance Company

C. Please summarize the Applicant's Insurance coverage by Long Term Care Insurance Policy# (Please indicate payment amount and length of duration of coverage)
_____

Do you have one of the following: **(Please circle yes or no)**

Legal Guardian Yes No

Name _____ Address _____

Home Phone #_____Work Phone #_____

Relationship_____

Power of Attorney Yes No

Name_____Address_____

Home Phone #_____Work Phone #_____

Relationship_____

Trustee Yes No

Name_____Address_____

Relationship_____

(If applicable, documentation will need to presented at time of admission for Power of Attorney, Trustee, and or Legal Guardian)

Financial Responsible Party (individual responsible for the payment of account)

Name _____ Phone # (H)_____(W)_____

Address_____ Relationship_____

Name _____ Phone # (H)_____(W)_____

Address_____Relationship_____

Current Monthly Income Amount

Social Security _____
Pension _____
Stocks and Bonds _____
Investment Income _____
Other _____

Capital Assets (including joint holdings)

Name of Bank _____
Address _____
Checking Account Amount _____
Savings Account Amount _____
Real Estate (owned/Mortgaged) _____
Life Insurance (list value) _____

(**Please list additional banks and account amounts on back of form)**

I fully understand that this is just an application and I will be placed on a waiting list. After acceptance for admission, I understand that a physical examination by my primary care physician or by our Medical Director is required before admittance to the facility. The examination is for medical evaluation and to insure proper placement for level of care.

Applicant's Signature _____Date_____