WELCOME

You have contacted this nursing home and indicated a desire to be admitted as a resident to this facility. Enclosed, please find this facility's written application form. As soon as you 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 complete and return this written application to us.

Port
REHABILITATION &
HEALTHCARE CENTER

Admission Policy & Procedure

- It is the policy of Port Rehabilitation and Healthcare center to treat all residents without regard to race, national origin, religion, sex, age, or financial status.
- Port Rehabilitation and Healthcare center is licensed by the State of Massachusetts Public Health Department as a Nursing Home for Chronic and Convalescent Care, Skilled Nursing Facility.
- Persons interested in having prospective residents considered for admission to the facility should obtain the "Application for Admission," the "Authorization for Release of Information," and the "transfer of Assets" forms from the Admissions office or website link www.porthc.com
- If it is determined that appropriate services can be provided by Port Rehabilitation and Healthcare center, the prospective resident will then be considered an "applicant." The application will verify the date and time of the applicant's placement on the waiting list, and/or telephone follow up by the Admissions Director.
- Applicants on the waiting list are offered admittance to Port Rehabilitation and Healthcare center in order as vacancies occur. An applicant offered admission must typically be seen by his/her physician within 1 year prior to admission.

Release of Information

Today's Date: _____

To Whom What May Concern:

I, _____, authorize the release to, and the use by, Port Rehabilitation and Healthcare center of any medical and psychiatric or other pertinent information needed in providing continuity of care for my welfare.

Applicant Signature_____ Date: __/__/____

Responsible Party/Legal Rep_____ Date: __/__/____

Transfer of Assets

Have you or your spouse sold, traded, given away, or transferred ownership of any motor vehicles, bank accounts, property of any kind, stocks, bonds, mutual funds, or cash during the past 36 months?

☐ Yes ☐ No

Have you or your spouse sold, traded, given away, or transferred ownership of any motor vehicles, bank accounts, property of any kind, stocks, bonds, mutual funds, or cash during the past 60 months?

☐ Yes ☐ No

Have you or your spouse established a trust fund or funded a trust with income or property of any kind with the past 6 months?

☐ Yes ☐ No

If yes, provide additional details (attach additional pages if needed):

_____

_____

_____

Have you or your spouse closed any type of account during the last 36 months?

☐ Yes ☐ No

If yes, explain below. Include the bank name, address, account number, and date closed:

_____

_____

_____

Resident's Signature_____ Date: __/__/____

Responsible Party/Legal Rep_____ Date: __/__/____

Application for Admission

First Name: _____ Last Name:_____
Address: _____
Phone:_____ Email:_____
Date of Birth: __/__/____ Place of Birth:_____ Citizen: Yes/No
Religion: _____ Marital Status: _____

PCP Name: _____ PCP Phone Number:_____

Mothers Maiden Name: _____ Birthplace: _____
Fathers Name: _____ Birthplace: _____

Nearest Relative/Guardian/Friend: _____
Relationship to Applicant: _____
Address: _____
Phone:_____ Email:_____

Is anyone legally authorized to act on your behalf? Yes/No
If yes, representative name: _____

Former Occupation: _____
Hobbies: _____

Medicare Number: _____ Medicaid Number: _____
Medicare Rx Company: _____ Medicare Rx ID Number: _____
MedEx Number: _____ Other Ins: _____

CONFIDENTIAL INFORMATION (Please list all potential sources including incomes/assets):
Savings: _____
Real Estate: _____
Life Insurance: _____
Social Security Amount: _____
Any other pensions: _____
Responsible party for payments: _____
Will you be eligible for the state medical assistance program (MassHealth) within 180 days of admission? Yes/No

BURIAL ARRANGEMENTS

Do you have a burial contact? Yes/No Undertaker: _____

Church: _____

Church Address: _____

Cemetary: _____

Cemetary Address: _____

In case of death, who will be responsible for funeral? _____

Phone: _____ Email: _____

Person to be notified about acceptance: _____

Address: _____

Phone: _____ Email: _____

CLINICAL INFORMATION: (Please use additional paper if neccessary)

Diagnoses: _____

_____

_____

_____

_____

Medications: _____

_____

_____

_____

_____

Allergies: _____

_____

_____

_____

_____

Resident's Signature_____ Date: __/__/____

Responsible Party/Legal Rep_____ Date: __/__/____

The above applicant will be on our waiting list as soon as we receive the complete forms.

Complete Application Receive: Yes/No Date Received: __/__/____