WINDEMERE
NURSING & REHABILITATION CENTER
An Affiliate of Martha's Vineyard Hospital, Massachusetts General Hospital, & a Member of Partner's Healthcare
One Hospital Road, Post Office Box 1747,Oak Bluffs, MA 02557 508-862-1951 www.windemeremv.org

ADMISSION APPLICATION

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

Please complete the following for the APPLICANT:

Name of Applicant: _____ Prefers to be called: _____
(last) (first) (middle)

Mailing Address: _____ Phone: (_____)_____
Street/POB # City State Zip

Date of Birth: _____ Age: _____ Birthplace: _____

Social Security Number: _____ Sex: ❒M ❒F Race: _____

Marital Status: ❒Single ❒Married ❒Widowed ❒Divorced Name of Spouse: _____

Primary Language: _____ US Citizen? ❒Yes ❒No (If no, how many years in US? _____)

How many full years living on Martha's Vineyard? _____ How many years at present address? _____

Are you a veteran? ❒Yes ❒No Was/Is your Spouse a veteran? ❒Yes ❒No

If yes to either of the above, which branch and dates of service? _____

Religious Preference: _____ Place of Worship: _____

Place of Worship Address: _____ Phone: (_____)_____
Street/POB # City State Zip

How did you hear about our facility? _____

Who should be contacted when a bed becomes available?

Name & Relationship to Applicant: _____Phone: (_____)_____

Mailing Address: _____ Alt. Phone: (_____)_____
Street/POB # City State Zip

Email Address: _____

RELATIVES AND/OR SIGNIFICANT OTHERS:

Persons to be notified in an emergency:

Primary Emergency Contact:

Name: _____ Phone (Home): (_____)_____

Relationship: _____ Phone (Work): (_____)_____

Address: _____ Phone (Mobile): (_____)_____

City, State, Zip: _____ Email Address: _____

Alternate Emergency Contact:

Name: _____ Phone (Home): (____)_____

Relationship: _____ Phone (Work) : (____)_____

Address: _____ Phone (Mobile):(____)_____

City, State, Zip: _____ Email Address: _____

Other Emergency Contact:

Name: _____ Phone (Home): (____)_____

Relationship: _____ Phone (Work) : (____)_____

Address: _____ Phone (Mobile):(____)_____

City, State, Zip: _____ Email Address: _____

MEDICAL INFORMATION:

Primary Care Physician: _____ Phone: (____)_____

Address: _____ Fax: (____)_____

Date of last visit: _____ Will physician follow in Nursing Home? ❒Yes ❒No

Primary Diagnosis: _____

Physicians consulted in past 2 years:

Name: _____ Phone: (____)_____

Address: _____ Specialty: _____

Name: _____ Phone: (____)_____

Address: _____ Specialty: _____

Name: _____ Phone: (____)_____

Address: _____ Specialty: _____

List hospitalization(s) in the past 12 months:

Name of Hospital Address Date

_____

_____

_____

HEALTH INFORMATION:

Ambulation: ❒Alone ❒Cane ❒Walker ❒With Assistance ❒Transfer bed to chair

❒Other (please describe): _____

Please list special equipment used by applicant: _____

Skin Condition: _____

Vision (please indicate if blind, needs glasses, etc.): _____

Hearing (please indicate of wears/needs hearing aids, hard of hearing, etc.): _____

CAPACITIES (please check where appropriate):

	Independent	*Dependent*	*Needs Help Sometimes*
Cooking/Housekeeping	❒	❒	❒
Dressing/Grooming	❒	❒	❒
Money Management	❒	❒	❒
Bathing	❒	❒	❒
Toileting	❒	❒	❒
Feeding	❒	❒	❒
Medication Administration	❒	❒	❒
Telephone	❒	❒	❒

CHARACTERISTICS (please check where appropriate):

Communication:	❒ Clear/Concise	❒ Alert	❒ Sometimes Clear
Expression:	❒ Uncommunicative	❒ Talks a Normal Amount	❒ Overly Talkative
Emotions:	❒ Depressed Often	❒ Normal Emotions	❒ Elated
Memory:	❒ Frequent Failure	❒ Unimpaired	❒ At Times Forgetful
Social Ability:	❒ Withdrawn	❒ Normal Social Ability	❒ Overly Boisterous
Anxiety:	❒ Worrier	❒ Worries Appropriately	❒ Denies Worry
Satisfaction:	❒ Demanding	❒ Appropriate Requests	❒ No Complaints
Activity:	❒ Remains Idle	❒ Normally Active	❒ Always Busy
Anger:	❒ Controlled ❒ Oriented	❒ Verbal Outbursts ❒ Confused	❒ Combative ❒ Disoriented

Past activities and interests: _____

Present activities and interests (last three months): _____

Is the applicant:

❒ a social person
❒ quiet/solitary person
❒ religious
❒ artistic, musical, poetic
❒ a gardener
❒ one who enjoys rides in the community
❒ one who likes to play games or cards (specifically) _____
❒ active (likes to walk/bike)
❒ other _____

If the applicant is legally blind, does he/she:
❒ have a talking book machine
❒ want a talking book machine (if yes, please notify your physician. A letter indicating the resident is legally blind will be needed before one can be ordered.

Family members and friends are welcome to join in the vast array of activities. On occasion, we need volunteers.

Would you or another family member or friend be available to volunteer? ❒Yes ❒No

Name: _____ Phone (Home): (____)_____

Relationship: _____ Phone (Work) : (____)_____

Name: _____ Phone (Home): (____)_____

Relationship: _____ Phone (Work) : (____)_____

Name: _____ Phone (Home): (____)_____

Relationship: _____ Phone (Work) : (_____)_____

Please describe any special characteristics or idiosyncrasies that might be helpful:

_____

_____

What is the applicant's present living arrangement?

❒ with a relative or friend
❒ at home alone
❒ at home with 24 hour care
❒ at home with daily care
❒ special housing for the elderly
❒ other (please specify): _____

If at home with some daily care, what care does the applicant receive?

DES Service	Hours	Community Agency Providing Service
Home Health Aid	_____	_____
Chore Worker	_____	_____
Meals on Wheels	_____	_____
Friends/Relatives	_____	_____
Other	_____	_____

CYCLE OF DAILY EVENTS:

Wakes up at _____ Naps regularly at _____ Bedtime _____

Please check all that apply:

Goes out ❒daily ❒weekly How often? _____
❒ Spends most time alone or watching t.v.
❒ Move independently indoors
❒ Stays in bed clothes much of the day
❒ Wakes up during the night for bathroom How often? _____
Prefers ❒ Shower ❒ Bath
❒ Daily contact with relatives/close friends How often? _____
❒ Usually attends religious service How often? _____ Which service? _____
❒ Daily animal companion/presence

Distinct food preferences (favorite foods): _____

Any food allergies: _____
❒ Eats between meals all or most days
❒ Use of alcoholic beverage(s) ❒ daily ❒ weekly How often? _____
❒ Smoke ❒ Cigarettes ❒ Cigars How many per day? _____ Per week? _____

SOCIAL HISTORY:

Has the applicant ever been treated for a nervous, emotional, or psychiatric disorder? ❒Yes ❒No

When and where? _____

Has the applicant ever been a resident of another home for the elderly? ❒Yes ❒No
If yes, where?
Name: _____ Phone : (_____)_____

Address: _____ Fax: (_____)_____

Does the applicant have a negative history of adjusting to physical and psycho-social losses? ❒Yes ❒No

If psychiatric condition is present, please provide a history of the condition, previous institutionalization and/or treatments: _____

_____

_____

FAMILY RELATIONSHIP:

Parents: ❒Living ❒Deceased (if deceased, please indicate how long, relationship with, etc.)

_____

Siblings: _____ Number living _____ Number deceased (if deceased, please indicate relationship/names of significant siblings, etc.)

_____

_____

Living Siblings:

Name: Age: Mailing Address: Phone:

_____

_____

_____

Children: _____ Number living _____ Number deceased (if deceased, please indicate relationship with children)

_____

_____

Living Children:

Name: Age: Mailing Address: Phone:

_____

_____

_____

Grandchildren: _____ Number (if indicate significant relationships, if any) _____

Name: Age: Mailing Address: Phone:

_____

_____

_____

SOCIAL BACKGROUND:

Education (indicate years of schooling, major in college, degrees obtained: _____

_____

Lifetime Occupation(s): _____

_____

Retirements (indicate date and reason for retirements): _____

_____

Political Involvement (registered voter, active interest, etc.): _____

_____

Community Involvement (indicate social/cultural interest, social groups, clubs, schools, etc.): _____

_____

_____

Additional comments: _____

_____

_____

FINANCIAL/BILLING INFORMATION:

Health Insurance (**Attach a copy** of the front & back of all cards)

Social Security Number: _____

Federal Medicare Number: _____

Medicare Part D Prescription Coverage Number: _____

Medex Number: _____

Other insurance: _____ Insurance Number: _____

State Medicaid Number: _____ Effective Date: _____

District Office: _____ Phone: (_____) _____

Long Term Care Insurance: _____

ADDITIONAL INFORMATION:

Do you have a… (please check "yes" or "no" for each item & attach a copy of instrument if checked "yes")

Living Will ❒Yes ❒No Do Not Resuscitate ❒Yes ❒No MOLST ❒Yes ❒No

Health Care Proxy ❒Yes ❒No Name: _____ Address: _____

Durable Power of Attorney ❒Yes ❒No Name: _____ Address: _____

Power of Attorney ❒Yes ❒No Name: _____ Address: _____

Guardianship ❒Yes ❒No Name: _____ Address: _____

Burial Arrangements ❒Yes ❒No Funeral Home: _____

Address: _____ Phone: (_____) _____

Cemetery: _____ Address: _____

Church/Pastor: _____ Phone: (_____) _____

DECLARATION OF FINANCES:

You are asked to complete the following financial section of this application. Should you have any questions or concerns, please contact the admission coordinator. ***This statement must be completed with copies of bank statements, burial contract, trusts, annuities, stocks, bonds, or life insurance policies the applicant may have. This section must be completed to be considered for admission.***

RESPONSIBLE PARTY (Guarantor): Individual responsible to assist resident in paying bills. This person is not financially responsible for the resident's bills.

Name: _____ Phone (Home): (_____)_____

Relationship: _____ Phone (Work) : (_____)_____

Address: _____ Phone (Mobile):(_____)_____

City, State, Zip: _____ Email Address: _____

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Monthly Income (applicant's only):

Social Security	$ _____	Annuity	$ _____
Disability	$ _____	Other	$ _____
Pension	$ _____	Other	$ _____
V.A. Benefits	$ _____		

Does the applicant receive any rental income? ❒Yes ❒No Amount received per month/year? $ _____

Cash Assets: (**Send a copy** of your passbooks updated within 45 days and/or **a copy** of your current statements, indicate if joint asset) i.e. Checking, Savings, NOW acct, Money Market, Certificates of Deposit (CD), Credit Union, Personal Needs Acct, including retirement accounts, IRA's, Keogh, or Pension Funds.

Name of Institution Name on Acct Acct # Type of Acct Balance As of Date

_____

_____

_____

_____

Securities: (**Send proof** of current value. Indicate if joint asset)

i.e. Stocks, Bonds, Savings Bonds, Mutual Funds, Securities, and Assets in safe deposit boxes, cash not in bank, options, or future contracts.

Investment Type Acct # Cash Value As of Date

_____

_____

_____

Annuities: (**Send a copy** of the contract)

Name(s) of owner(s): _____

Name of Institution:_____

Contract Number: _____

Date Purchased: _____
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Real Estate Assets:

Does the applicant own a home? ❒Yes ❒No Approximate Value: $ _____

Is the property mortgaged? ❒Yes ❒No Amount Owed: $ _____

Location: _____

Are there other occupants of the primary dwelling? ❒Yes ❒No

Please list: _____

Does the applicant own other property? ❒Yes ❒No Approximate Value: $ _____

Is this property mortgaged? ❒Yes ❒No Amount Owed: $ _____

Location: _____

Are there other occupants of this dwelling? ❒Yes ❒No

Please list: _____

Life Insurance:

Does this applicant have a life insurance policy with a cash value? ❒Yes ❒No (**Send a copy** of the first page)

Approximate Cash Value: $ _____ Name of Insurance Company: _____

Face Value of Policy: $ _____ Beneficiary: _____

Liabilities:

Please list all debts, obligations, mortgages, liens, credit balances, etc., that may affect the above listed assets or income statements.

_____

_____

_____

_____

Transfer of Assets:

Item Transferred	Approximate Value	To Whom	Approximate Date

Trusts: (**Send a copy** of the Trust document(s), any amendments, documents showing financial activity, and the schedule of Beneficiaries)

Are you the Donor, Grantor, Trustee, or Beneficiary of any trust? ❒Yes ❒No Revocable ❒Yes ❒No

Are you the Beneficiary of a Trust established by someone else? ❒Yes ❒No Revocable ❒Yes ❒No

Name of Trust: _____ Type: _____

Grantor/Donor: _____ Trustee: _____

Beneficiary: _____ Trust: _____

Principle: _____

Prepaid Burials: (**Send a copy** of the Trust, contract, insurance policy, or burial-only account)

Contract Amount: $_____Burial Trust Amount: $_____Burial Plot ❒Yes ❒No

Insurance Company: _____ Policy Number: _____ Bank:_____

Account Number:_____ Life Insurance for Burial Total Face Value: $_____

REFERRAL INFORMATION:

Type of stay requested:

❒ Wildflower Court -Independent Living

❒ Ocean View - Skilled Nursing and Long Term Care

❒ Lagoon View - Skilled Nursing and Long Term Care

Please identify Institution if applicant currently resides in a Nursing Home:

Name: _____

Address: _____ Phone (_____) _____

Contact Person: _____ Length of Stay: _____

Has a Medicaid (Mass Health) Pre-admission nursing home screening (Request for Services) been completed to determine nursing home clinical eligibility? ❒Yes ❒No

Has the applicant been receiving services from community programs? ❒Yes ❒No

Please identify: _____

_____

_____

AUTHORIZATION

I understand and agree that *this application is neither a contract, nor a reservation for residence.*

Nothing contained in this document is legally binding on either myself or Windemere Nursing & Rehabilitation Center.

I certify that the foregoing statement is accurate to the best of my knowledge. Furthermore, I understand that Windemere considers this application as a continuing statement of financial condition and I agree to notify Windemere of any substantial change in my financial condition. Windemere agrees to keep all information contained herein confidential.

_____ _____

(Print) Name of Applicant or Responsible Person Signature of Applicant or Responsible Person

_____

Date of Application