

MOUNT PLEASANT HOME



APPLICATION FOR ADMISSION

Date: _____

A. INTRODUCTORY INFORMATION

1. NAMES

Applicant's Full Name: _____

Person preparing application, if different: _____

Relationship to Applicant: _____

Phone: _____ Email: _____

Other Contact Information: _____

2. Applicant's **SOCIAL SECURITY NUMBER**: _____

3. CONTACT INFORMATION

Current Address: _____

How long at this address? _____

Telephone Numbers: _____

4. PERSONAL HISTORY

Previous Address: _____

Birth Date: _____ Birth Place: _____

Maiden Name: _____

If Veteran, list Service Branch: _____ Dates: _____

If Spouse is a Veteran, list Branch: _____ Dates: _____

Citizen? Yes No, Alien Registration #: _____

Current Marital Status:

Married Single Widowed Divorced Separated

5. FAMILY & FRIENDS MOST INVOLVED IN CARE

Does the Applicant have a legal Power of Attorney, Conservator, or Health Care Proxy currently in place? If so, please check appropriate legal relationship, complete contact information below, and attach copy of the particular legal document indicating such a relationship.

Power of Attorney Conservator Guardian

Name: _____ Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Other Contact Info? _____

Healthcare Proxy

Name: _____ Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Other Contact Info? _____

Applicant's Parents: *(Full names are necessary for some assistance programs)*

Father's Full Name: _____

Mother's Full Name: _____

Applicant's Children:

Number of Children: _____

Complete contact information for all children and family members: full name, address, all phone numbers, and e-mail.

Name: _____ Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Other Contact Info? _____

Name: _____ Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Other Contact Info? _____

Name: _____ Relationship: _____

Address: _____

Home #: _____ Work #: _____ Cell #: _____

Email: _____ Other Contact Info? _____

Other Relatives or Interested Friends

Complete contact information for other relatives/interested friends: full name, address, all phone numbers, and e-mail. Identify any special legal relationship (e.g., power of attorney, conservator, health care proxy).

Name: _____ **Relationship:** _____

Address: _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Email: _____ **Other Contact Info?** _____

Name: _____ **Relationship:** _____

Address: _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Email: _____ **Other Contact Info?** _____

Name: _____ **Relationship:** _____

Address: _____

Home #: _____ **Work #:** _____ **Cell #:** _____

Email: _____ **Other Contact Info?** _____

B. BACKGROUND INFORMATION

1. EDUCATION

_____ High School

_____ College/Other

2. OCCUPATIONS: _____

_____ Date Last Employed:

3. ORGANIZATIONAL MEMBERSHIPS: _____

4. RECREATION: Interests and Hobbies: _____

5. DINING: Preferences and Nutritional Requirements: _____

6. RELIGIOUS AFFILIATION: _____

7. RELIGIOUS AFFILIATION: _____

_____ Contact Person & Phone:

8. FUNERAL & BURIAL ARRANGEMENTS

Cemetery: _____

Deed held by: _____

Burial Insurance (Company/Policy #): _____

Funeral Director: _____

C. HEALTH INFORMATION

1. PHYSICIANS

Primary Care Physician: _____

Address: _____ Telephone: _____

Hospital/Clinic: _____

Specialty Physician: _____ Specialty: _____

Address: _____ Telephone: _____

Hospital/Clinic: _____

Specialty Physician: _____ Specialty: _____

Address: _____ Telephone: _____

Hospital/Clinic: _____

2. CARE HISTORY & STATUS

Date of last treatment or exam: _____

Details of hospitalization(s) within the last ten years: _____

Have you ever been a resident of a retirement or nursing home? No Yes

If Yes, provide details below, including **Name & Location of Facility**, and Dates of Stay. _____

Have you appointed anyone to serve as your **Health Care Proxy** to act on your behalf in the event you become unable to make health care decisions for yourself? No Yes

If Yes, Name/address/phones/e-mail: _____

Do you expect to need assistance with **Personal Care**? No Yes

If Yes, explain: _____

Have you ever **smoked** cigarettes, pipes, or cigars? No Yes

Do you currently **smoke** cigarettes, pipes, or cigars? No Yes

If yes, how many cigarettes or times a day do you **smoke**? _____

Do you understand that Mount Pleasant Home is a **non-smoking facility** and that smoking is allowed outside only? No Yes

D. HOSPITAL AND MEDICAL INSURANCE

Please provide the following details *in addition to* a copy of each insurance card.

- Medicare: Part A (Hospital Insurance) Part B (Medical Insurance)
 Medicare Number: _____ Effective Date: _____
- Medicare Part D – Prescription Drug Plan:
 Name of Plan: _____ ID Number: _____
 RxBin: _____ RxPCN: _____
 RxGroup: _____ RxIssuer: _____
 Effective Date of Plan: _____
 Phone Number of Plan: _____
 Other Important Information: _____
- MassHealth (Medicaid): ID Number: _____
- Other Medical Insurance: _____

	ID No.
Name of Company	
	ID No.
Name of Company	

E. CONFIDENTIAL FINANCIAL INFORMATION

The following information is necessary to determine how the cost of residency at Mount Pleasant Home will be paid, either privately or through eligibility for public payment subsidies. Should you at any time have questions or concerns, please contact the Social Worker or Executive Director. This statement must be updated at the time of admission and periodically thereafter, upon request.

1. RESPONSIBLE PARTY

Individual responsible for paying bills, if other than applicant:
 Name: _____ Relationship to Applicant: _____
 Complete Home Address: _____

 Telephone Numbers: _____

home
business
mobile/other

2. MONTHLY INCOME

List income from *all* sources.

SOURCE	MONTHLY AMOUNT	COMMENTS/ACCOUNT #S
Social Security	\$ _____	_____
Pension 1 (list source in comments)	\$ _____	_____
Pension 2 (list source in comments)	\$ _____	_____
Annuity (list source in comments)	\$ _____	_____
Interest/Dividends	\$ _____	_____
Supplemental Security Income (SSI)	\$ _____	_____
Supplemental Security Disability Income (SSDI)	\$ _____	_____
Other (list source in comments)	\$ _____	_____
TOTAL MONTHLY INCOME	\$ _____	

3. ASSETS

Real Property:

Check here if None: Otherwise, list details below

REAL ESTATE LOCATION	NET VALUE (=market value – mortgage balance)
Property 1: _____ If jointly held, Co-owner's Name: _____	\$ _____
Property 2: _____ If jointly held, Co-owner's Name: _____	\$ _____
Total Real Estate Value:	\$ _____

Bank Accounts:

Check here if None: Otherwise, list details below

BANK OR FINANCIAL INSTITUTION NAME	ACCOUNT TYPE (checking, savings, etc.)	CURRENT BALANCE	ESTIMATED ANNUAL INTEREST
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____

Investment Accounts:

Check here if None: Otherwise, list details below

INVESTMENT INSTITUTION NAME	INVESTMENT TYPE (MUTUAL FUND, STOCKS, ETC.)	CURRENT BALANCE	ESTIMATED ANNUAL DIVIDENDS
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____
_____	_____	\$ _____	\$ _____

Are any of these assets held jointly? No Yes

If Yes, explain: _____

Are there any obligations against or restrictions on any of these assets? No Yes

If Yes, explain: _____

Are any of these assets held in trust? No Yes

If Yes, explain: _____

Trust Officer's Name/Address/Phone: _____

Have you made substantial gifts or transfers to any person, persons, or organizations in any of the previous three (3) years? No Yes

If Yes, explain: _____

4. LIFE INSURANCE AND ANNUITIES

INSURANCE COMPANY NAME	CASH VALUE	MONTHLY ANNUITY (if applicable)
_____	\$ _____	\$ _____
_____	\$ _____	\$ _____

Mount Pleasant Home reserves the right to request income tax returns for the three (3) most recent years to confirm income and determine eligibility for public payment subsidies.

Comments regarding financial information:

Is it your belief that your income and assets will be adequate to meet your monthly fee to Mount Pleasant Home and your other living expenses during your residence? No Yes

If no, explain: _____

F. AFFIRMATION

These statements and information entered above are true to the best of my/our knowledge and belief. I/we agree that I/we will not make substantial gifts or transfer assets of surplus income so that any remaining assets are insufficient to meet my/our financial obligation to Mount Pleasant Home. If personal resources are now or become in the future inadequate to meet the costs of living at Mount Pleasant Home, I/we agree to provide the necessary documentation to establish and or maintain eligibility for payment through appropriate subsidy programs.

Signature: _____ Date: _____
Applicant

Signature: _____ Date: _____
Responsible Party (Individual named in Section E, Part 1)

MOUNT PLEASANT HOME



Send this application to:

MOUNT PLEASANT HOME
Attn: Social Work
301 S. Huntington Ave.
Jamaica Plain, MA 02130

Info@MountPleasantHome.org

617-522-7600
Fax: 617-522-0201

We thank you and will contact you shortly!

MEDICAL RECORDS RELEASE

APPLICANT:

Fill out the following information to allow Mount Pleasant Home to contact your health care provider and obtain your medical records.

Provider Name: _____

Hospital/Facility: _____

Address: _____

Phone: _____

Fax: _____

To Whom It May Concern:

I hereby authorize the release of any or all of my medical records to:

MOUNT PLEASANT HOME
301 S. Huntington Ave.
Jamaica Plain, MA 02130

617-522-7600
Fax: 617-522-0201

Print Name: _____

Signature: _____

PHYSICIAN’S STATEMENT

APPLICANT:

Bring this form to your physician or ask Mount Pleasant to fax it to your provider.

PHYSICIAN:

Your patient has applied for residency at Mount Pleasant Home, a level IV rest home, in Jamaica Plain, MA. We are licensed by the Massachusetts’ Department of Public Health as a long-term care facility to provide housing, support services, and medical oversight in a residential setting. Mount Pleasant administers medications, schedules medical appointments, serves three meals daily, and has 24-hour staff to respond to residents who are more capable of living on their own but who do need assistance in certain areas. We emphasize a nurturing, safe, and supportive environment where elders can live as independently as possible.

The Department of Public Health requires that each resident have a Primary Care Physician and that we have a record of the health of a resident prior to moving in. This information will be used to help us determine whether Mount Pleasant Home will be a good match for your patient. Thank you for your assistance.

Please fill out the following information:

Patient Name: _____ Gender: M F DOB: _____

Home Address: _____

Date of most recent physical examination: _____

Allergies: _____

Diagnosis (ACTIVE medical problems):

Pertinent INACTIVE medical problems, medical history:

Emotional/psychological history limiting patient’s ability to live independently:

Treatments (specific orders and frequency); special needs:

Diet: _____

Please check the appropriate status for each of the following:

1. Medication Monitoring

- Complete self-management and self-administration of all medications
- Needs only supervision and some assistance to self-administer
- Needs only supervision to self-administer
- Needs administration by licensed personnel

2. Ambulation

- Fully independent
- Needs supervision
- Needs assistance

4. Bathing

- Fully independent
- Needs supervision
- Needs assistance

6. Dressing

- Fully independent
- Needs supervision
- Needs assistance

8. Grooming/Personal Hygiene

- Fully independent
- Needs supervision
- Needs assistance

10. Smoking Management

No smoking is allowed within the building at Mount Pleasant Home.

- Not Applicable
- Fully independent
- Needs supervision
- Needs assistance

3. Eating

- Fully independent
- Needs supervision
- Needs assistance

5. Toileting

- Fully independent
- Needs supervision
- Needs assistance

7. Transferring

- Fully independent
- Needs supervision
- Needs assistance

9. Nutrition Management & Compliance

- Fully independent
- Needs supervision
- Needs assistance

I approve of _____'s residency at Mount Pleasant Home.

Physician Signature: _____

Physician Name: _____

Hospital/Clinic: _____

Address: _____

Telephone: _____

Email: _____

Date: _____