

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.



Admission Policy & Procedure

- It is the policy of Sippican Rehabilitation and Healthcare Center to treat all residents without regard to race, national origin, religion, sex, age, or financial status.
- Sippican 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.sippicanhc.com
- If it is determined that appropriate services can be provided by Sippican 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 Sippican 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, Sippican 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: _____

Cemetery: _____

Cemetery 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: __/__/__