HANNAH B.G. SHAW HOME, INC.
299 Wareham Street
Middleboro, MA 02346
Telephone: 508-947-0332
Fax: 774-213-9846

APPLICATION FOR ADMISSION

The following is an application for admission to The Hannah B.G. Shaw Home. Please forward completed application to Admissions Director.

Please complete the following:

Name: _____
(Last) (First) (Middle)

Current Address: _____ Phone (_____) _____

City: _____ State: _____ Zip: _____

Gender: ❑ Female ❑ Male

Date of Birth: _____ Age: _____ Place of Birth: _____

Marital Status: ❑ Married ❑ Divorced ❑ Widowed ❑ Single ❑ Separated

Primary Language: _____ US Citizen? ❑ Yes ❑ No

Are you a Veteran? ❑ Yes ❑ No Was/Is Your Spouse a Veteran? ❑ Yes ❑ No

Lifetime Occupation: _____ Education: _____

Religion: _____ Place of Worship: _____

How did you hear about this Home? _____

Service applying for: ❑ Long-Term Care ❑ Memory Care ❑ Residential Care

NEAREST PERSONS TO CONTACT IN CASE OF EMERGENCY

Primary Emergency Contact

Name: _____ Telephone (Home): _____
Relationship_____ (Work): _____
Address: _____ (Cell): _____
City: _____ State: _____ Zip: _____
Email Address**:** _____

Alternate Emergency Contact

Name: _____ Telephone (Home): _____
Relationship_____ (Work): _____
Address: _____ (Cell): _____
City: _____ State: _____ Zip: _____
Email Address: _____

PHYSICIANS

Primary Care: _____ Telephone: _____
Address: _____ Fax: _____
Date of last visit: _____

Physicians consulted in past 2 years:

Name: _____ Telephone: _____
Address: _____ Specialty: _____
City/State/Zip _____

Name: _____ Telephone: _____
Address: _____ Specialty: _____
City/State/Zip _____

Name: _____ Telephone: _____
Address: _____ Specialty: _____
City/State/Zip _____

INSURANCE INFORMATION

HEALTH INSURANCE ***(Kindly provide front & back copies of all insurance cards.)***

Social Security Number: _____
Federal Medicare Number: _____
Medicare Part D Prescription Coverage Number: _____
Other Insurance: _____ Policy Number: _____
State Medicaid #: _____ Effective Date: _____
Long Term Care Insurance: _____

ADDITIONAL INFORMATION

DOES APPLICANT HAVE A:

(Please check YES or NO for each item & attach copy of document if checked YES)

MOLST ❑ **YES** ❑ **NO**

HEALTH CARE PROXY ❑ **YES** ❑ **NO**
Name: _____ Address: _____

POWER OF ATTORNEY ❑ **YES** ❑ **NO**
Name: _____ Address: _____

GUARDIANSHIP ❑ **YES** ❑ **NO**
Name: _____ Address: _____

DECLARATION OF FINANCES

Please complete the following section and provide copies of bank statements, burial contract, trusts, annuities, stocks, bonds, or life insurance policies the applicant may have.

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

Name:_____ Relationship to Resident:_____
Home Address: _____ City:_____
State: _____ Zip:_____ Telephone:_____

ASSETS

Real Estate/Vehicle Ownership:

Real Estate Location: _____
Net Value (*market value minus mortgage balance*): _____
Automobile: Make: _____ Model: _____ VIN # _____

Bank Accounts:

Name of Bank	Account Type	Current Balance

Investment Accounts:

Location	Account Type	Current Balance

Stocks and Bonds:

Location	Type *(stock, bond, etc.)*	Current Value

Life Insurance:

Do you have a whole life insurance policy? Yes_____ No_____
Approximate cash value: $_____ Face Value: $_____
Company Name: _____

Prepaid Burials:

Location: _____
Type: *(irrevocable, etc.)* _____
Date Purchased: _____
Cost: _____

LIABILITIES:

Mortgage Balance:

Name of Bank	Bank Address	Current Balance

Credit Card Balance:

Name of Credit Card Co.		Current Balance

Other Loans:

Name of Loan	Account Type	Current Balance

SSI Payable:

Explanation of Payback	Current Balance

Other Liabilities:

Type of Liability	Current Balance

-These assets and liabilities balances are as of _____ (date).

- Are there any assets or liabilities held jointly? Yes _____ No _____

If yes, explain:_____

- Has there been any transfer of assets (including but not limited to money, stock, and real estate) within 60 months (5 years) prior to this application? Yes _____ No_____

If yes, please give detail:

Asset: _____ Value: $_____ Date of Transfer: _____

Asset: _____ Value: $_____ Date of Transfer: _____

MONTHLY INCOME:

Social Security _____	$_____
Pensions (from) _____	$_____
Annuities (from)_____	$_____
Interest & Dividends (from) _____	$_____
S.S.I (copy of card)_____	$_____
S.S.D.I._____	$_____
Other_____	$_____
Total Monthly Income:	**$_____**

FUNERAL ARRANGEMENTS:

Funeral Home: _____
Address: _____
Phone Number: _____

Where does applicant reside at time of application: _____

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

_____

_____

_____

_____

_____

Hospital utilized within the last 60 days:

Name: _____ Address: _____ Dates: _____

Reason: _____

Nursing Home or Rehab Facility utilized within the last 60 days:

Name: _____ Address: _____ Dates: _____

Reason: _____

Nursing Home Applicants, please fill in the information requested below.
(Not applicable for Residential Care Applicants)

By definition, a patient in Massachusetts is considered private paying until their individual assets are spent down to the Massachusetts Medicaid Eligibility Limit of $2,000.00. Anyone who has less than $2,000.00, upon application, would be eligible to apply for Massachusetts Medicaid Assistance through the Massachusetts Department of Human Services (Masshealth), prior to admission. In order for our Home to project the private pay and Medicaid census, we request your assistance in completing the following information.

Based on the above criteria, applicant would be: (Please select one)

- ❑ Private Pay
- ❑ Active Standard Medicaid (Masshealth policy)
- ❑ Have applied for Medicaid with decision pending
- ❑ Will need to apply for Medicaid

I hereby certify that to the best of my knowledge and belief, the information stated in this application is true, correct and complete. I understand that if any information has been falsely represented or any material omissions made, such misrepresentation or omission would constitute sufficient cause for voiding my application for admission and may be a basis for liability for any unpaid charges to The Hannah B.G. Shaw Home. All of the information will be kept confidential by The Hannah B.G. Shaw Home.

I understand and agree that the foregoing application is not a contract or reservation for residence. Nothing contained herein is binding on either party until an Admission Agreement has been signed by the parties hereto.

Signature of Applicant/Responsible Party _____ Date: _____

STATE LAW PROHIBITS FACILITIES FROM DISCRIMINATION BASED UPON RACE, CREED, COLOR, NATIONAL ORIGIN, SEX, AGE, DISABILITY, MARITAL STATUS, SEXUAL ORIENTATION OR SOURCE OF PAYMENT.