Saint Elizabeth Community
Just like family

Application for Admission

Saint Elizabeth Home
One Saint Elizabeth Way
East Greenwich, RI 02818
Phone (401) 471-6060
Fax (401) 471-6056

Saint Elizabeth Manor
1 Dawn Hill Road
Bristol, RI 02809
Phone (401) 253-2300
Fax (401) 410-0011

The following is an application for admission to our community. Please complete this application, and return it to the location of your choice 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:

Name_____
First Middle Last

Address_____ Town/City_____

State_____ Zip_____ Telephone _____

Date of Birth_____ Age _____ Sex_____

Marital Status M___ D___ W___ S ___ Religion _____

Recommended by _____

Reason for Long Term Care

Please provide a brief description of the applicant's medical needs _____
_____
_____
_____
_____

Dementia Yes No In need of immediate admission Yes No

Recent Hospital and/or Nursing Home Stays

Date _____ Location _____
Date_____ Location _____

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Contact Information of Relative or Responsible Party

Name_____ Phone # (H)_____ (W)_____

Address_____ City/Town _____

State _____ Zip _____ Relationship _____

E Mail Address _____

Financial Power of Attorney

Name _____ Phone _____

Relationship _____

Healthcare Power of Attorney

Name _____ Phone _____

Relationship _____

Physician

Primary Care Physician _____ Phone _____

Address _____

Financial / Billing Information

Health Insurance (Kindly provide copies of all cards)

Social Security #_____
Federal Medicare #_____ Medicare Part B Yes No
State Medicaid #_____
Other (name) _____ #_____

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Part I

By definition, a patient in Rhode Island is considered private paying until their individual assets are spent down to the RI Medicaid Eligibility Limit of $4000.00. Anyone who has less than $4000.00, upon application, would be eligible to apply for RI Medicaid Assistance through the RI Department of Human Services, prior to admission. In order for our home to project the Private Pay and Medicaid Census, we request your assistance in completing the following questions.

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

Private Pay or Medicaid Eligible

A. If paying privately, the applicant estimates that they would remain private paying for how many months/ years _____

B. If there is a need for Medicaid Long Term Care Assistance, the applicant has:
Applied with a decision of eligibility ____
Applied with decision pending ____
Not begun application yet ____
A need to obtain further information regarding the Medicaid application ____

Part II

A. The applicant has Long Term Care Insurance Yes No

B. If yes, with whom is the applicant insured?_____
Name of Insurance Company

C. If yes, please summarize the applicant's coverage by the Long Term Care Insurance Policy: (Please indicate the payment amount and length of duration of coverage)

_____

_____

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Current Monthly Income

	Amount
Social Security	_____
Pension	_____
Stocks and Bonds	_____
Investment Income	_____
VA Benefits	_____
Other	_____

Capital Assets (including holdings jointly held)

	Amount
Checking Account	_____
Savings Account	_____
Real Estate (owned and mortgaged)	_____
Life Insurance (list value)	_____
Other	_____

I fully understand that this is just an application for the waiting list. I also understand that medical information will be required prior to placement.

Applicant/Responsible Name (please print) _____

Signature of Applicant/Responsible Party _____

Date_____