Saint Elizabeth Community
Where RI seniors come first

Application for Admission

Please check residence for which you are applying and number in order of preference. 1st , 2nd and 3rd.

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

☐**The GREEN HOUSE® Homes**
at Saint Elizabeth Home
One Saint Elizabeth Way
East Greenwich, RI 02818
Phone (401) 471-6060
Fax (401) 471-6072

☐**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 ________________________

Contact Information of Relative or Responsible Party

Name______________________________Phone # (H)______________(W)_____________

Address____________________________City/Town ____________________

State__________Zip___________ Relationship ______________________

E Mail Address ____

Financial Power of Attorney (please include a copy of the POA)

Name______________________________________ Phone ___________________

Relationship ________________________________

Healthcare Power of Attorney (please include a copy of the POA)

Name______________________________________ Phone ____________________

Relationship ________________________________

Physician

Primary Care Physician_________________________Phone ____________________

Address ____

Financial / Billing Information

Health Insurance (please 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

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)
____
____

D. Burial Plan Yes No
E. Funeral Home ____

Address, Phone ____

Current Monthly Income

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

Capital Assets (including holdings jointly held)

(Please provide current account statements or a certified letter from a bank official for all financial assets)

	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______________