SAINT ELIZABETH HOME
Trusted Care Since 1882

Application for Admission

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

☐ **Saint Elizabeth Home**
Phone (401) 471-6060
Fax: (401) 471-6056

☐ **The GREEN HOUSE® Homes at Saint Elizabeth Home**
Phone (401) 471-6060
Fax: (401) 471-6056

1 St Elizabeth Way
East Greenwich, RI 02818

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

Contact #1

Name_____ Phone(H)_____ (C)_____

Relationship_____ Email_____

Address_____ City/town_____ State_____ Zip_____

Contact #2 (*if applicable*)

Name_____ Phone(H)_____ (C)_____

Relationship_____ Email_____

Address_____ City/town_____ State_____ Zip_____

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) _____ #_____

**Please be advised that Aetna insurance plans and VA benefits are not accepted.*

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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 _____

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)
_____

_____

D. Burial Plan Yes No

E. Funeral Home _____

Address, Phone _____

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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)

(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_____