SAINT ELIZABETH ASSISTED LIVING

Formerly The Seasons

Application For Admission

Traditional _____ Memory Care _____ Date Recv'd _____

5 Saint Elizabeth Way East Greenwich RI 02818 Telephone: 401-884-9099 Fax: 401-884-7439

The following is an application for admission to Saint Elizabeth Assisted Living, East Greenwich. Criteria for admission is the same for all persons without regard to race, gender, national origin, physical or cognitive impairments.
Please call with any questions or for assistance with completing this application.

General Information

Applicant's Name _____
(*First Name*) (*Middle Initial*) (*Last Name*)

Address _____ Social Security _____

City_____ State _____ Zip _____ Date of Birth _____

Phone _____ Age _____

Present Residence is: Home _____ Apartment _____ Other _____

Marital Status _____ If married, then spouse's name _____

Care Team

Primary Care Physician (PCP) Name: _____

Phone _____ Address _____

Specialty _____Name _____

Phone_____Address_____

Specialty _____Name _____

Phone_____ Address_____

Hospital Preference _____

Emergency Contact

Name: _____ Relationship: _____

Address:_____City_____ State_____ Zip_____

Tele: (H) _____ (W) _____ (Cell) _____

Email: _____

Second
Name: _____Relationship: _____

Address:_____City_____ State_____ Zip_____

Tele: (H) _____ (W) _____ (Cell) _____

Email: _____

Insurance

Medical Insurance: Type: _____ Policy#: _____
(*Blue Cross, UHC, AARP etc.)*

Federal Medicare # _____ Part A _____Part B _____

Other Insurance Type: _____ Policy #: _____

Long Term Care Provider _____ Policy# _____

Financial Resources

Total assets including home: _____ (please provide supporting documentation)

Your monthly income: Social Security _____ Pension: _____ Trusts: _____

Other: _____

Funeral Home Preference _____ Phone_____

Financial Responsible Party
(Individual who will receive the invoice and ensure payment)

Name: _____ Relationship: _____

Address:_____City_____ State_____ Zip_____

Tele: (H) _____ (W) _____ (Cell) _____

Email: _____

List all Health Conditions:_____

_____

Allergies: _____

List any Behaviors that might require extra supervision such as wandering, elopement risk and sundowning:

_____

Mobility: _____Independent _____Cane _____Walker _____Self-propelled Wheelchair

_____Other-explain: _____

I need Assistance with:

_____Medication Administration _____Bathing _____Dressing _____Escort Service

_____Housekeeping & Laundry _____ Incontinence Mgt. _____Other-explain: _____

Applicant's Signature_____ Date: _____

I fully understand that this is just an **application** for Saint Elizabeth Assisted Living, East Greenwich **waiting list**.