A History of Gracious Living

SEVENTY-FIVE STATE STREET

Preliminary Admission Information

Personal Information

Date ______________________

Name ______________________ Birthdate ______________________

Address ______________________ Telephone ______________________

Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Medicare # ______________________ Blue Cross Certificate # ______________________

Other insurance ______________________ ID# ______________________

Social Security # ______________________

Present Living Arrangements

☐ In my own home/apt. ☐ With relative/friend ☐ Assisted Living

☐ Support services such as Meals on Wheels or Homemakers come to my home.

Occupancy

Seventy Five State Street has both Independent and Assisted Living (Residential Care).
The Marketing Director will review the programs with you to help decide which best suits your needs.
Review the information packet for a listing of services in each program.

I am interested in:

☐ Assisted Living ☐ Independent Living ☐ Unsure

Family Members/Personal Contacts

Completely list family members and/or friends whom we should contact on your behalf in the event of an emergency or situation requiring intervention.

Name	Relationship	Address	Phone (home & work)

Preliminary Admission Information

Legal Affairs

☐ I have already completed a document outlining my End of Life Decisions (Living will).
☐ I have already completed a Power of Attorney. Please specify:
☐ Durable ☐ Financial ☐ Healthcare
My agent is: ________________________________
☐ I have made a decision with my doctor regarding resuscitation.
(Copies of all above indicated documents will be requested for admission)
☐ I manage my financial affairs independently.
☐ My financial affairs are managed by: ________________________________
☐ I have a Conservator or Guardian.

Education

Circle last year completed
Primary School 1 2 3 4 5 6 7 8 9 10 11 12 __________ GED ________
Yr graduated
College 1 2 3 4 ___________ Degree ________________________
Yr. graduated

Occupation

Please indicate your area(s) of employment: ________________________________

Medical Data

Detailed information will be required for all applicants. We will request this from your physician with your permission.

Regular Physician ____________________ Hospital preference ____________________
Dentist ____________________ Optometrist ____________________
Other specialist ____________________ Allergies ____________________

Dietary Needs

Appetite: Good ______ Fair ______ Poor ______
Special dietary considerations ________________________________
Foods unable to tolerate ________________________________
Food allergies ________________________________

Comments

Please use the space below to record any important details that have not been covered in the application form:

Admission Process

1. Complete and submit preliminary admission form.
2. Submit medical information from your physician, including your most recent history and physical exam.
3. Participate in an informal admissions meeting with two of our staff members.
   After completing the above process we will respond within two business days to inform you of our decision to accept the application or report any concerns we may have in meeting the needs of the applicant.

Signatures

Signature of applicant____Date_________

If other than applicant, name of person to contact in follow up to the application:

Name____Phone___________________________

If you have any questions about the information requested or need help in completing this application, please do not hesitate to call us @ **207-775-7775**.

75 State Street Portland, Maine 04101 Phone: 207-775-7775 Fax: 207-772-2896

Confidential Financial Assessment

There are three methods of payment for the cost of Assisted Living. Please indicate your proposed method of payment and complete the appropriate information.

☐ 1. Monthly payment with private funds.

☐ 2. Long term care insurance

Private long-term care insurance policies may have provisions for coverage of Assisted Living services.

Name of insurer ______________________ ID# ______________________

Contact person ______________________ Tel. # ______________________

We will request a copy of your policy

☐ 3. Medicaid

The applicant or responsible party must make application with the Department of Human Services. Once approved, the resident makes a monthly payment to the facility as calculated by the Dept. of Human Services. Medicaid then makes a supplemental payment to the facility.

Status:

☐ Currently receives community Medicaid. ID#______________________

☐ Application for assisted living Medicaid coverage made.

Date application filed______________________________________

DHS Caseworker ______________________________________

Monthly income		**Assets**	
Social Security	__________	Bank Accounts	__________
Pensions	__________	Real Estate (current market value)	__________
Interest/dividends	__________	Stocks, bonds, & securities (current market value)	__________
SSI	__________	Other possessions of significant value	__________
State Assistance	__________	Insurance policies	__________
All other income	__________	Mortuary Trust	__________
Total monthly income	__________	Total Assets	__________