Marillac Residence
Residential Care Community

Application for Resident Admission

Please answer all questions and provide requested documentation. Incomplete applications will not be considered for admission.

Date Application Submitted: _____ Date Seeking Admission: _____

Name of Applicant: _____

Address: _____

Mailing Address, if different from home address: _____

Telephone #: home: _____ cell: _____

Social Security Number: _____

Date of Birth: _____ Place of Birth: _____
(DD/MM/YYYY)

Marital Status: Never Married: ____ Married: ____ Widowed: ____ Divorced: ____

Name of Spouse: _____

Primary Language: _____ Primary Occupation: _____

Religion: _____ Clergy contact: _____

Place of Worship: _____ Funeral Home: _____

Primary Care Physician: _____

Address: _____ Phone: _____

Medical Specialists/Consultants:
Name: _____ Specialty: _____

Name: _____ Specialty: _____

Please tell us why you are seeking admission to Marillac Residence at this time:

_____

_____

Current Medical and Functional Status of Applicant:

Do you have any health conditions that require regular/daily attention or monitoring?
(Insulin dependent diabetes, blood pressure, skin condition, oxygen use) Yes ____ No ____

If yes, please describe: _____

Who monitors this condition now? _____

Height: _____ Weight: _____ Date: _____

Please list all your medications, including over the counter, vitamins, supplements, etc.

Medication Name	Dose	Directions	Prescribing Physician	Start Date

If more space is needed, please attach another page.

Do you have assistance taking your medications? Yes _____ No _____
If yes, describe the assistance: _____

Have you tested positive for Covid-19? Yes_____ No_____ If Yes, when: _____
Have you been vaccinated against Covid-19? Yes___ No____.
If Yes, what vaccine did you received and when? _____
Have you received a Covid Booster Vaccine? Yes ____ No ___ If Yes, when? _____
Please include a copy of your Covid–19 vaccination card.

Are you on a special diet? Yes ____ No_____
If yes, please explain: _____

_____

Please list any allergies: _____
_____

Are you physically active? Yes ____ Somewhat_____ No ____
What kinds of activities do you enjoy? _____

Do you use a: Cane ____ Walker _____ Rolling Walker ____ Other (please specify)? _____

Do you require any special accommodations? Yes ____ No ____
If yes please specify: _____

Have you fallen in the last 6 months: Yes ____ No_____ If yes, how many times? _____
Did you suffer any injuries from the fall? Yes_____ No _____
Please describe your injuries: _____

Have you had any hospitalizations in the last 90 days? Yes ____ No _____
If yes, what were you admitted for: _____
How long were you in the hospital? _____

Are you Incontinent of: Bladder Yes ___ No ____ Bowel: Yes ____ No ____

Do you presently have any of the following?
Hearing Aids ____ Eye Glasses _____ Contact Lens _____ Dentures _____ CPAP machine _____

ADLs:
Assistance Required with Activities of Daily Living: Please check all that apply.

Activity	**Independent**	**Need Some**	**Total Assist**	**Comments**
Dressing/ Grooming				
Bathing /Showering				
Medications				
Bed Making				
Laundry				
Safety Awareness				

Do you have a history of depression or any other mental health issues which required hospitalization, psychiatric support services or use of psychotropic medications and/or ECT? Yes ____ No____
Date or Age of Onset of Diagnosis: _____

Are you currently receiving treatment for this condition? If yes, please describe: _____
_____

Please attach a copy of your most recent physical exam report. Prior to admission, we will need an order from your primary care physician that admission to Marillac Residence is socially and medically appropriate.

RESPONSIBLE PARTY CONTACT INFORMATION

Health Care Proxy #1

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip Code: _____

Telephone #'s home: _____ cell: _____ work: _____

Email: _____

Health Care Proxy #2 (if applicable)

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip Code: _____

Telephone #'s home: _____ cell: _____ work: _____

Email: _____

Power of Attorney: (if applicable)

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip Code: _____

Telephone #'s home: _____ cell: _____ work: _____

Email: _____

Next of Kin

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip Code: _____

Telephone #'s home: _____ cell: _____ work: _____

Email: _____

Additional Emergency Contact Name(s):

Name: _____ Relationship: _____

Address: _____ City/State: _____ Zip Code: _____

Telephone #'s home: _____ cell: _____ work: _____

Please add additional names on the back of this page, if needed.

Financial Information:

Insurance Information

Medicare Part A (Hospital Insurance) Yes ___ No _____ ID # _____

Medicare Part B (Medical Insurance) Yes ___ No ____

Is your Medicare Part B premium deducted from your social Security payment? Yes ___ No ____

Medicare Part D (Prescription Drug Plan) Yes __ No ___

Insurance company: _____ ID# _____

Is your Medicare Part D premium deducted from your social Security payment? Yes ___ No __

MassHealth (Medicaid) Yes ____ No ___ ID# _____

Dental Plan Yes ___ No ____ Insurance Company & ID# _____

Long Term Care Insurance Yes____ No____ Insurance Company & ID # _____

(Please attach a copy of the policy)

Other Medical Insurance Yes ___ No ___ ID# _____

Name of Insurance_____ Type of Insurance _____

(Medicare Supplement, PPO, HMO)

Sources of Income – (please indicate amounts received monthly)

Social Security $_____

Retirement Pension $ _____

Annuities / Investments $ _____

Other: $ _____ explain: _____

Other: $ _____ explain: _____

Real Estate Assets

Applicant's Primary Residence (if owned) Tax Assessed Value? _____

Property owned jointly or individually? _____

If jointly, with whom: _____

Do you own additional property? Yes _____ No _____ Value: $_____

Location of property_____

Have you created a trust or transferred assets in the last 60 months? Yes ____ No _____

If yes, please explain**:** _____

Please list all other assets and investments including stocks, bonds, trusts, mutual Funds, IRA's, Life Insurance, etc. including present value:

Name of Bank / Institution	**Type of Account**	**Value**
_____	_____	**$**_____
_____	_____	**$**_____
_____	_____	**$**_____
_____	_____	**$**_____

*I hereby state to the best of my knowledge that all the information above is accurate, complete and true.
*I understand that any information that has been falsely represented, will be sufficient cause for voiding this application for admission.
*I understand and agree that this application is neither a contract nor a reservation for residence.
*I understand that I may contact Marillac Residence to provide any updates or changes to the above information.

Signature of Applicant: _____ Date: _____

Application Package checklist: Please include the following:

1. Complete application
2. Photocopy of all health insurance cards
3. Photocopy of: Health Care Proxy Form, Power of Attorney
4. Current Medication list, including dosages
5. Primary Care Physician Statement (included with this application)
6. Copy of Covid-19 vaccination card (if applicable)

Please return complete application and other documentation to:

Marillac Residence
Attention: Admissions
125 Oakland Street
Wellesley Hills MA 02481-5338