CHERRY BROOK
Health Care Center
A division of New Horizons, Inc.

Admission Application

* All information supplied shall remain confidential. Application cannot be processed without this form.

Resident Name: ______________________________

Home address: ______________________________
____

Are You a U.S. Citizen? ☐Yes ☐ No

Phone#: ______________________________

Present Location: ______________________________

If hospital, date of admit: ______________________________

Current living arrangements: ______________________________

Location for the past 5 years (list all addresses)
____
____
____
____
____

Date of birth: ______________________________

Birthplace: ______________________________

Marital Status: ______________________________

Religion: ______________________________

Former Occupation: ______________________________

Community physician: ______________________________

Hospital preference: ______________________________

Pharmacy preference: ______________________________

Funeral preference: ______________________________

Prepaid funeral account? ☐ Yes ☐ No

Have arrangements been made? ☐ Yes ☐ No

Will prior living accommodations be available after placement? ☐ Yes ☐ No

Have any HOME CARE services been used in the past? ☐ Yes ☐ No Agency? ______________________________

How does applicant plan to pay for cost of care? ______________________________

Does the applicant have an ADVANCE DIRECTIVE? ☐ Yes ☐ No

Have arrangements been made to be an ORGAN DONOR? ☐ Yes ☐ No

Emergency Contact

Contact 1
Name: ______________________________
Relationship: ______________________________
Address: ______________________________
Phone # (Home): ______________________________
Phone # (Work): ______________________________

Contact 2
Name: ______________________________
Relationship: ______________________________
Address: ______________________________
Phone # (Home): ______________________________
Phone # (Work): ______________________________

Contact 3
Name: ______________________________
Relationship: ______________________________
Address: ______________________________
Phone # (Home): ______________________________
Phone # (Work): ______________________________

Contact 4
Name: ______________________________
Relationship: ______________________________
Address: ______________________________
Phone # (Home): ______________________________
Phone # (Work): ______________________________

Type of Stay

☐ **REHAB** ☐ **HOSPICE** ☐ **RESPITE** ☐ **LONG TERM CARE** ☐ **ASSISTED LIVING**

We will need copies of the following:
(copies can be made if desired)

- ► **MEDICAID Card (both sides)**
- ► **MEDICARE D Card (both sides)**
- ► **Insurance Card (both sides)**
- ► **Green Card (both sides if applicable)**
- ► **Living Will**
- ► **Power of Attorney & Conservatorship Documents**

Thank you for taking the time to complete this application. Please tell us how you heard about this facility.
____

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Financial Disclosure

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Resident Name: ____________________

Social Security #: ____________________ Medicare #: ____________________

Medicare D#: ____________________

Medicaid #: ____________________ Pending as of: ____________________

MassHealth#: ____________________ Pending as of: ____________________

DSS Case Worker: ____________________ Phone #: ____________________

Other Medical Insurance: ____________________ Policy ID#: ____________________

Life Insurance Company: ____________________ Surrender Value: $____________________

Does applicant own a partnership-approved long term care insurance policy? ____________________

Other long term care insurance: ____________________ Company: ____________________

Current Monthly Income

Social Security: $____________________ Where is this mailed?____________________

Pension: $____________________ Where is this mailed?____________________

VA Benefits: $____________________ Where is this mailed?____________________

SSI: $____________________ Where is this mailed?____________________

CDs: $____________________ IRAs: $____________________

Annuities: $____________________ Dividends: $____________________

Other Income: $____________________

Does Applicant have a Trust: □ Yes □ No If yes, explain: ____________________

Cash Asset	Bank	Account #	Type	Amount

Current Non Liquid Assets: $____________________

Real Estate

Does the applicant own any property? □ Yes □ No

Type & location: ____________________

Names on deed: ____________________

Estimated value: $____________________ Payable on mortgage: $____________________

Has there been any sale or transfer of property/assets (liquid/non-liquid) within the past 60 months? □ Yes □ No

If yes, please specify amount & to whom: ____________________

Was applicant and/or spouse a member of the US Armed Forces? □ Yes □ No Branch: ____________________

Where has the applicant been within the past 60 days?: ____________________

____

If applicant is unable to handle their financial affairs, to whom can outstanding bills be sent for payment?

Name: ____________________ Phone: ____________________

Address: ____________________

Relationship to applicant: ____________________

____________________ ____________________

Signature of Person Completing Application Date

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Medical Data

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Resident Name: ______________________________
Current Physician: ______________________ Will physician be following? □ Yes □ No
Current Diagnosis: ______________________________
Past Medical History: ______________________________
Medications: ______________________________

Nursing Needs

Indicate all that apply

Ambulation

□ Independent
□ With Assist
□ Walker
□ Cane
□ Wheelchair
□ Bedbound
□ Transfers
□ Ind.
□ Assist of
□ 1 □2

Continence

□ Continent
□ Incontinent
□ Bowel
□ Bladder
□ Foley Catheter
□ Texas Catheter
□ Sup. Pub. Cath.
□ Ostomy (type)
____

Feeding

□ Independent
□ With Assist
□ Total Assist
□ Feeding Tube
□ NG Tube
□ Gastric
□ J-tube
□ Rate
□ Solution
□ Special Diet ______________________

Bathing

□ Independent
□ With Assist
□ Total Care

Dressing

□ Independent
□ With Assist
□ Total Care

Adaptive Equipment: (type) ______________________________
____

Mental Status

□ Alert
□ Understands
□ Forgetful
□ Confused
□ Non Responsive
□ Oriented
□ Disoriented

Behavior

□ Cooperative
□ Depressed
□ Withdrawn
□ Belligerent
□ Noisy
□ Needs Restraints
□Wanders
□ Combative

Miscellaneous

Weight ______________________
Height ______________________
□ Hearing Impaired ______________
□ Speech Impaired ______________
□ Vision Impaired ______________
□ Dentures ______________________
□ Allergies ______________________
□ Skin:
□ Intact ______________________
□ Reddened ______________________
□ Open Area
□ Size ______________________

Therapies Received: ______________________
Therapies Needed: □ P.T. □ O.T. □ Speech

Treatments: ______________________________
____

Other Pertinent Medical Information: ______________________________
____
____