Catholic Memorial Home
2446 Highland Avenue
Fall River, MA 02720
Telephone (508) 679-0011
Fax (508) 679-9995

Madonna Manor
85 North Washington Street
North Attleboro, MA 02760
Telephone (508) 699-2740
Fax (508) 699-0481

Marian Manor
33 Summer Street
Taunton, MA 02780
Telephone (508) 822-4885
Fax (508) 880-3386

Our Lady's Haven
71 Center Street
Fairhaven, MA 02719
Telephone (508) 999-4561
Fax (508) 997-0254

Sacred Heart Home
359 Summer Street
New Bedford, MA 02740
Telephone (508) 996-6751
Fax (508) 996-5189

Application for Admission

Please attach copies of the applicant's Social Security, Medicare, Mass Health or other Insurance cards. For your convenience, cards may be copied at the facility. Thank you.

For Office Use Only.
Date Received _____
Admission Date _____
Roster # _____
Room # _____
Short-term ___ Long-term ___

Personal Information

Name: _____
Previous address: _____
Phone: _____ Email: _____
Date of birth: _____ Place of birth: _____
Sex: _____ U.S. citizen: Yes ___ No ___
Marital status: M ___ S ___ W ___ D ___ Sep ___
Spouse's name: _____ If deceased, date: _____
Religion: _____
Name of Clergy: _____
Church: _____
Town/City: _____
Attending physician: _____
Address: _____ Phone: _____

Referred by: _____

Next of Kin

#1: _____ Phone (home): _____
Address: _____ (work): _____
_____ Relationship: _____
Email: _____
#2: _____ Phone (home): _____
Address: _____ (work): _____
_____ Relationship: _____
Email: _____

Responsible Party *(You may indicate one of the relatives listed above or another individual.)*

Name: _____ Phone (home): _____
Address: _____ (work): _____
_____ Relationship: _____
Email: _____

Have you made provisions for:

Durable Power of Attorney Yes ___ No ___
Health Care Proxy Yes ___ No ___
Legal Guardianship Yes ___ No ___

Health History

Dates last hospitalized From: _____ To: _____

Where: _____

Diagnosis: _____

_____

Present health conditions: _____

_____

Prior nursing home placement, if any: _____ Dates: _____

_____ _____

History of psychiatric illnesses: _____ Hospitalization dates: _____

_____ _____

History of infectious illnesses: _____ Dates: _____

_____ _____

Income/Payment Source Information

Date of Retirement: _____

Social Security #: _____ Amount: _____

Medicare #: _____ Part A___ B___ Effective Date: _____

Mass Health (Medicaid) #: _____

Medex #: _____

HMO: _____ # _____

Other insurance: _____ # _____

Private pay Yes ____ No ____ If yes, estimated assets to cover facility costs? _____

Other pensions/income/veterans benefits: _____ Amount: _____

_____

Are you currently applying for Mass Health (Medicaid)? Yes_____ No _____

Name of case worker (if available): _____

Name of funeral director: _____

Address: _____

Prepaid burial: Yes_____ No _____

Life insurance: Yes_____ No _____

Signature: _____

Relationship to applicant (If other than applicant's signature above): _____

Date: _____

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