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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