



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.

PERSONAL INFORMATION

Name: _____
 Previous address: _____
 Phone: _____
 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: _____

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

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: _____

For Office Use Only