Stone Rehabilitation and Senior Living
277 Elliot Street
Newton Upper Falls, MA, 02464
P: 617.527.0023
F: 617.965.7531

Date ______/______/________

Application for Admission

Name ___________________________________
Address __________________________________
____
Telephone (____) _______________________
Birthday ______________ Age _____________
Birthplace ____________ Citizen____________
Religion ______________ Marital Status ____
Spouse's Name ___________________________
If Deceased, Date of Death ________________

Social Security #____________________
Medicare#_________________________
Supplemental #____________________
Other Insurance ____________________
Medicaid #_________________________

Father's Name _____________________
Mother's Maiden Name ______________

Work History, Previous Occupation

Previous Occupation: ____
Education Level: ____
Veteran:_____________ Branch: _________________ Dates of Service: ______________________________

Responsible Person (Health Care Proxy/ Power of Attorney)

Name ____ Relationship ______________________________________
Address __________________________________ City ___________________ State _____ Zip Code ___________
Tel: (Home) (____) _________________ (Work) (______) ___________________ (Cell) (_____) _______________
Health Care Proxy? __________________________________ **If yes, please provide a copy**

Financial Manager

Name ____ Relationship____________________________________
Address _______________________________ City ______________________ State _____ Zip Code ___________
Tel: (Home) (____) _________________ (Work) (______) ___________________ (Cell) (_____) _______________
Is there Power of Attorney? ____________________________ **If yes, please provide a copy**

Current Status of Applicant

Applicant is now at ____
Address _____________________________ City _______________________ State _____ Zip Code ___________
Contact Person ____ Telephone (_____) _______________
Physician ____ Telephone (_____) _______________
Address _______________________________ City ______________________ State _____ Zip Code ___________
Medical Diagnoses____
Allergies ____
Mental Status ____

Financial Information

Sources of Income:

	Recipient's Name	Monthly Amount
Social Security	____	$________________
Retirement/Pension	____	$________________
V.A. Pension	____	$________________
Rental Income	____	$________________
Annuities/Investments	____	$________________
Other (Specify)	____	$________________

Assets:

Name of Bank	Type of Account	Value
__________________________________	__________________________	________________
__________________________________	__________________________	________________
__________________________________	__________________________	________________
__________________________________	__________________________	________________
__________________________________	__________________________	________________

Do you own: Stocks ______________ Bonds ____________ CD's _____________ Mutual Funds _____________

Approximate Value ____

Insurance Company ____

Policy Number ____

Face Value ____

Have you created a trust or transferred assets? Yes ____________ No __________

If yes, please explain ____

Do you own a home? Yes _______ No ________ Live Alone? Yes __________ No ___________

Do you have Long Term Care Insurance? Yes ________ No__________

Company ______________________________________ Policy Number ______________________________

Address ____ Telephone (   )_________________________

Emergency Contact(s)

Name	Complete Address	Relationship	Telephone (Cell/Home)

1. ____

2. ____

Burial Arrangements

Funeral Home ____

Address ____ Tel: (   )__________________

*** I hereby state that to the best of my knowledge and belief, the above stated information is true, correct, and complete. All of the information will be kept confidential by Stone Rehabilitation, and will not be released without my written permission.**

Signature of Applicant ____ Date ___________________

Signature of Responsible Party ______________________________________ Date ___________________

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Date: _____/_______/____________

Physician ____________________________

Address______________________________

____

Telephone (______) ____________________

MEDICAL REPORT FOR ADMISSION
PLEASE TYPE OR PRINT

Name of Applicant ____ Date of Birth ___/____/_______
Address ____

Diagnosis:____
____
____

Current Medications:
____
____

Previous Medical or Surgical History
____
____

COVID Vaccine No ☐ Yes ☐ Date: Influenza Vaccine No ☐ Yes ☐ Date:

COVID Booster No ☐ Yes ☐ Date:

Allergies: No ☐ Yes ☐ List Allergies:
____

Is special diet required?__________ If so, please give details____________________________
____

Chief Complaints: ____
____

PLEASE ANSWER IN DETAIL **PHYSICAL EXAMINIATION**

General Condition Ambulatory Wheelchair Bedridden
Skin Thyroid Height Weight
Vision Hearing
Teeth Speech
Lungs Blood
Continence ☐ Bowel ☐ Bladder Incontinence ☐ Bowel ☐ Bladder

Does applicant have any physical disabilities? Please state fully:
____

Does applicant have any mental impairments? Please describe in detail whether or not applicant is alert, forgetful, cooperative, and list any behaviors:
____
____