

APPLICATION FOR ADMISSION

Date: _____

Name of applicant: _____

Preferred name: _____

Address: _____

Video Phone #: _____

Email: _____

Date of Birth: _____

Place of Birth: _____

Social Security #: _____

Birth Certificate copy provided

State ID Card copy provided

Gender Expression Male Female Other

Medicaid/MassHealth ID: _____ copy provided

Medicare Beneficiary ID: _____ copy provided

Other medical insurance: _____ copy provided

LTC insurance: _____

List of current medications: _____

Medical History: _____

A History and Physical examination performed within the last 90 days, including current medication list, must be submitted for review by the clinical director.

Demographics (OPTIONAL)

Citizenship US Canadian Other

Marital Status Never married Married Widowed Divorced

Ethnicity White Black/African American Hispanic/Latino Other

Religion _____

Education _____

Occupation _____

Revised 07/2021



New England Homes for the Deaf

Senior Living for the Deaf Since 1901

Financial Information

In order to process your application, we need to verify a source of payment for the stay at our facility. Please make sure that all information is complete and accurate as discrepancies will delay processing of the application.

Monthly Income	YES/NO	Amount	Provided
Social Security	_____	_____	<input type="checkbox"/> check copy provided
SSI	_____	_____	<input type="checkbox"/> check copy provided
Veterans benefits	_____	_____	<input type="checkbox"/> check copy provided
Pension / Annuity	_____	_____	<input type="checkbox"/> check copy provided
Other (indicate)	_____	_____	<input type="checkbox"/> check copy provided

Assets	YES/NO	Value	Provided
Residence – own	_____	_____	<input type="checkbox"/> property tax bill
Other real estate	_____	_____	<input type="checkbox"/> property tax bill

Bank accounts	YES/NO	Value	Provided
Checking	_____	_____	<input type="checkbox"/> last 5 years
Savings	_____	_____	<input type="checkbox"/> last 5 years
Certificates of Deposit	_____	_____	<input type="checkbox"/> last 5 years

Investments	YES/NO	Value	Provided
Stocks / Bonds	_____	_____	<input type="checkbox"/> last 5 years
Life Insurance	_____	_____	<input type="checkbox"/> current statement
Prepaid burial account	_____	_____	<input type="checkbox"/> contract

Has anyone been designated as:

- Power of Attorney **(copy provided)**

Name, Address and Phone #

- Guardian **(copy provided)**

Name, Address and Phone #

- Health Care Proxy **(copy provided)**

Name, Address and Phone #

Revised 07/2021