ETHAN PLACE ASSISTED LIVING

85 Ethan Street
Warwick, Rhode Island 02888
(401) 781-5460

APPLICATION FOR ADMISSION

Last Name First Name Middle Name :	Date	Do you smoke?	
Current Address		Telephone Number	
Sex	Date of Birth	Place of Birth	
Spouse's Name	Spouse's Address	18. Spouse's Birth Date / Date of Death	
Resident of Rhode Island From: To:	Citizen of U.S Yes \No	. Is this a Readmission? Yes No	
Medical Insurance Claim Numbers Medicare Part A#_____ Blue Cross#_____ Medicaid #_____ Medicare Part B# Blue Shield # Other#			
Name and Address of Next of Kin, Relative or POA (Primary Contact for Health Care/Financial Decisions)		Telephone Number	

Resident monthly fees are payable in advance and are due on the 1st day of each month. Resident monthly fees include:

- 3 meals per day and 2 healthy snacks.
- Utilities, heat, electricity and water.
- 24 hour staffing.
- Medication Administration, storage and preparation.
- Ordering and delivery of medication (optional).
- Personal care assistance to help with activities of daily living to include showers.
- Housekeeping; safe and comfortable environment.
- Personal Laundry Assistance (detergent provided by resident).
- Access to facility common areas.
- Wi-Fi and Basic Cable access.
- Arranges transportation for appointments (optional).
- Social Activities, entertainment and activity programs.

Resident responsibilities include:

- Co-pays for prescriptions
- Personal needs money
- Appropriate room furnishings if required to include room air conditioners.

FINANCIAL STATEMENT

Name:_____ **Date:**_____

INCOME

LIST ALL YOUR INCOME (If additional space is needed. please attach a separate sheet.)

ANSWER EVERY ITEM	NO	YES	PEND-ING	Amount Received	How Often Received
Earnings from Employment					
Social Security Pension					
Veteran'sPension					
Veteran's Compensation					
Other Government Pensions					
Private Pensions					
Dividends					
Interest					
Workmen's Compensation					
Temporary Disability Insurance					
Annuities or Insurance					
Other: Specify Source					
Monthly Rental Fee	Provided	By Ethan	Place	$	
Excess Income				$	
Balance Required from other Funds (List sources below)				$	

All the above entries must be documented with bank statements and payment notices.

_____ _____

Date Signed **Applicant or Next of Kin**

MEDICAL CERTI FICATE

TO BE COOMPLETED BY PHYSICIAN ONLY

I. Patient's Name	DOB:	Age:
2. Examining Physician: (Print Name)		
Address:		
3. Date of Examination:		
4. Diagnosis and History of Previous Illness (including any hospitalization, surgeries):		
		Code Status
		CMO
		DNR
5. Provide documentation of code status.		DNI
6. Allergies:		
7.. Diagnosis and Symptoms of Present Illness:		
8. Diagnosis and History of Psychiatric Illness (include previous hospitalizations and dates):		
9. History of Abuse?		
10. Laboratory - Workup/ Results		
11. Diagnostic Test(s) Results:		
12. Last: Dental Visit:	Eye Exam:	Podiatry Exam:

Patient:	YES	NO
A. Ambulation: D Independent D Assistance Use of: Cane Walker/Rollator Wheelchair		
B. Performs without assistance, Activities of Daily Living, such as brushing teeth, bathing, combing hair, body eliminations		
C. Dress him/her self with a minimum of assistance		
D. Needs total assistance dressing him/her self		
E. Feeds him/her self without assistance		
F. Secure medical attention: Is able to address his/her own medical needs		
G. Body Eliminations I. Voluntary Control 2.Incontinent Bowel/Bladder		
H. Makes rational and competent decisions as to medical, legal, financial matters		
I. Has DMAT been completed by PCP? If so date completed (complete if NO to question H)		
J. In need of continuous nursing care?		
K. In need of secured unit due to wandering?		
L. Suitable for assisted living?		
M. Vaccinated for Flu? (Date)		
N. Vaccinated for COVID-19? (Date)		

Physician Signature

REPORT OF INTERVIEW

Date

Signature

FOR OFFICE USE ONLY