Shrewsbury Nursing & Rehabilitation Center
40 Julio Drive Shrewsbury, MA 01545
T: 508-887-1857 F: 508-841-4788

Welcome

You have contacted this nursing home and indicated a desire to be admitted as a resident to this facility.

Enclosed, please find this facility's written application form. As soon as you complete and return the form to the facility, your name will be placed on our waiting list for admission to the facility. Your name will only be placed on our waiting list after you complete and return this written application to us.

Thank you,

Shrewsbury Nursing & Rehabilitation Center

Admission Policy and Procedure

It is the policy of Shrewsbury Nursing & Rehabilitation Center to treat all residents without regard to race, national origin, religion, sex, age, or financial status.

Shrewsbury Nursing & Rehabilitation Center is licensed by the State of Massachusetts Public Health Department as a Nursing Home for Chronic and Convalescent Care, Skilled Nursing Facility.

Persons interested in having prospective residents considered for admission to the facility should obtain the "Application for Admission," the "Authorization for Release of Information," and the "transfer of Assets" forms from the Admissions office or website link www.shrewsburynursing.com

If it is determined that appropriate services can be provided by Shrewsbury Nursing & Rehabilitation Center, the prospective resident will then be considered an "applicant." The application will verify the date and time of the applicant's placement on the waiting list, and/or telephone follow up by the Admissions Director.

Applicants on the waiting list are offered admittance to Shrewsbury Nursing & Rehabilitation Center in order as vacancies occur. An applicant offered admission must typically be seen by his/her physician within 1 year prior to admission.

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Release of Information

Today's date _____

To Whom What May Concern:

I, _____, authorize the release to, and the use by, Shrewsbury Nursing & Rehabilitation Center of any medical and psychiatric or other pertinent information needed in providing continuity of care for my welfare.

Applicant Signature_____ Date _____

Responsible Party/Legal Rep. _____ Date _____

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Medicaid (Masshealth) - Information Required for Medicaid Eligibility
Transfer of Assets

Resident Name: _____

Have you (or your spouse) sold, traded, given away, or transferred ownership of any motor vehicles, bank accounts, property of any kind, stocks, bonds, mutual funds or cash during the past 36 months?

☐ Yes ☐ No

Have you (or your spouse) sold, traded, given away, or transferred ownership of any motor vehicles, bank accounts, property of any kind, stocks, bonds, mutual funds or cash during the past 60 months?

☐ Yes ☐ No

Have you (or your spouse) established a trust or funded a trust with income or property of any kind with the past 60 months?

☐ Yes ☐ No

If yes, provide additional details (attach additional pages if needed).

_____
_____
_____

Have you (or your spouse) closed any type of account during the last 36 months?

☐ Yes ☐ No

If yes, explain below. Include the bank name, address, account number and date closed.

_____
_____
_____

Signature

Resident's Signature _____ Date _____

Responsible Party/Legal Rep. _____ Date _____

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Application for Admission

Applicant Information

First Name: _____ Last Name:_____

Address: _____

City/Town: _____ State: _____ Zip code:_____

Phone: _____ Email: _____

Date of Birth: _____ Place of Birth: _____ Citizen: ☐ Y ☐ N

Religion: _____ Marital Status: _____

PCP Name:_____ PCP ph #:_____

Mother's Maiden Name: _____ Birthplace:_____

Father's Name: _____ Birthplace: _____

Nearest Relative, Guardian or Friend: _____

Relationship to Applicant: _____

Address: _____

City/Town: _____ State: _____ Zip code:_____

Phone: _____ Email: _____

Is Anyone Legally Authorized to Act on your behalf? ☐Y ☐N

If yes, Representative name:_____

Former Occupation: _____

Hobbies: _____

Applicant Personal Information

Medicare No: _____ Medicaid No: _____

Medicare Rx Company: _____ Medicare RX ID No: _____

Medex No: _____ Other Insurance: _____

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Application for Admission

Confidential Information *Please list all potential sources (including income/assets)*

Savings: _____

Real Estate: _____

Life Insurance: _____

Social Security Amount: _____

Any Other Pensions? _____

Who will be responsible for payments? _____

Will you be eligible for State's medical assistance program (MassHealth) within 180 days of admission?

☐ Y ☐ N

Burial Arrangements

Do you have a burial contract? ☐ Y ☐ N Undertaker: _____

Church: _____

City/Town: _____ State: _____

Cemetery: _____

City/Town: _____ State: _____

In case of death, who will be responsible for funeral? _____

Phone: _____ Email: _____

Person to be notified about acceptance: _____

Address: _____

City/Town: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Clinical information: (Please use additional paper if necessary)

Diagnoses:

_____
_____
_____
_____
_____

Medications:

_____
_____
_____
_____
_____

Allergies:

_____
_____
_____
_____

Signature

Resident's Signature _____ Date _____

Responsible Party/Legal Rep. _____ Date _____

The above applicant will be on our waiting list as soon as we receive the completed forms.

Complete application received? ☐ Y ☐ N Date received: _____