ORIOL HEALTH CARE
Our family taking care of yours

FINANCIAL ASSESSMENT

The Information provided in this assessment is used to determine if the person named below qualifies financially and if he/she needs financial assistance through MassHealth insurance. Please complete this form in its entirety and be as thorough as possible.

*PLEASE NOTE IF YOU ARE APPLYING FOR MASS HEALTH (MEDICAID), THE LOOK BACK PERIOD IS 5 YEARS. THIS IS TO DETERMINE WHETHER THERE HAVE BEEN ANY DISQUALIFYING ASSET TRANSFERS.

Facility Choice:

Holden☐ Oakdale☐ First Available☐ Wachusett Respiratory Unit☐

Readiness for placement: ☐ASAP ☐Currently in the Hospital ☐ Planning for the future

Applicant's Name:_____ Date of Birth:_____ Age:__ Sex: M☐ F☐

Residential Address: _____

Street City State Zip code

Telephone#_____ Does applicant live alone? ☐Yes ☐No with whom?_____

Do you: Rent☐ Own☐ Life Estate☐

*If you Own the property at the address listed above, please list below full name and telephone numbers of ALL persons listed on the deed:

Name:	Telephone#
_____	_____
_____	_____
_____	_____

U.S. Citizen: ☐YES ☐NO Social Security Number: _____ Religion: _____

Were you in the armed forces? ☐YES ☐NO If so, Dates of service: _____

Marital Status: ☐Married ☐Single ☐Widowed ☐Separated If Widowed or Separated, as of what date: _____

Name of Spouse: _____ Primary Language:_____

Financial Manager /Responsible Party (other than applicant)

Please provide the information below for the person(s) who handles or assists in handling financial matters for the applicant. At least one person who is not the applicant needs to be listed. Person or Persons listed will be responsible to sign the Facility Admission agreement upon acceptance for long term Care.

Name/ Relationship:_____

Address_____

Telephone#:._____ Email:._____

Name/ Relationship:_____

Address_____

Telephone#:._____ Email:._____

Please check type of authority (if any) and provide a copy with this application:

☐Legal Guardian ☐Durable Power of Attorney ☐Conservator

☐Representative Payee ☐Joint Account Holder

Health Care Proxy

Name:_____Relationship:_____

Address: _____

Street City State Zip code

Telephone:_____ Email:_____

*Please include a copy of the health care proxy with this application.

If no health care proxy, please provide the name of an emergency contact:

Name:_____Telephone:_____

Current Living Situation

Applicant is currently residing at:_____

This is: ☐My Home ☐ Skilled Nursing Facility ☐Assisted Living Facility ☐Hospital ☐Other

Address:_____

Street City State Zip code

Health Insurance

Medicare#:_____ ☐Part A only ☐Part B only ☐Part D ☐Part A & B

Part D Prescription coverage provider: ID#:_____

HMO Name:_____ID#:_____

Massachusetts Medicaid (Mass Health) #:_____

Long Term care insurance: _____Policy#:_____

* Please include a copy of your Long-Term Care insurance policy upon acceptance for admission

Funeral/Burial Arrangements

Do you have a Burial only savings account? ■YES ☐NO

If Yes, Name of Bank: _____

Funeral Home:_____Telephone#:_____ City:

_____State:_____

Have arrangements been pre-paid? ■YES ☐NO

Monthly Income

Please list all incomes below. if applicant needs MassHealth insurance for long term care and has a Spouse, please list all of Spouses income. This information is needed to help determine MassHealth coverage.

	Applicant	Amount	Spouse	Amount
Social Security:	_____	$_____	_____	$_____
Retirement (pension 1):	_____	$_____	_____	$_____
Retirement (Pension 2):	_____	$_____	_____	$_____
VA Pension:	_____	$_____	_____	$_____
Rental Income:	_____	$_____	_____	$_____
Other Income:	_____	$_____	_____	$_____

Financial Information/Assets – Applicant

Name of Bank	Type of Account	Owner of Account	Current account balance
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____

Have you closed any accounts in the past 5 years? ☐YES ☐NO

If Yes:

Name of Bank	Type of Account	Owner of Account
_____	_____	_____
_____	_____	_____

Do you own: ☐Stocks ☐Bonds ☐CD's ☐Mutual Funds Approximate Value:_____

Life insurance policy: Company name:_____ Policy#:_____

Beneficiary Name:_____Whole or Term:_____

Have you created a trust: ■YES ☐NO Date created: _____ (please provide a copy with this application)

If so what type: ☐ Revocable ☐Irrevocable ☐Realty ☐Special Needs

Has there been a transfer or gift of more than $750.00 in the past 5 years? ■YES ☐NO

If yes, please explain:_____

Do you own any real estate other than your residential address listed? ■YES ☐NO

If yes, please list address(s) below:

_____

_____

Financial Information/Assets – Spouse

Section only to be filled out if applicant needs MassHealth coverage for long term care and has a living spouse who resides in the community

Name of Bank	Type of Account	Owner of Account	Current account balance
_____	_____	_____	$_____
_____	_____	_____	$_____
_____	_____	_____	$_____

Have you closed any accounts in the past 5 years? ☐YES ☐NO

If Yes:

Name of Bank	Type of Account	Owner of Account
_____	_____	_____
_____	_____	_____

Do you own: ☐Stocks ☐Bonds ☐CD's ☐Mutual Funds Approximate Value:_____

Life insurance policy: Company name:_____ Policy#:_____

Beneficiary Name:_____ Whole or Term:_____

Have you created a trust: ☐YES ☐NO Date created: _____ (please provide a copy with this application)

If so what type: ☐Revokable ☐Irrevocable ☐Realty ☐Special Needs

Has there been a transfer or gift of more than $750.00 in the past 5 years? ☐YES ☐NO

If yes, please explain:_____

Do you own any real estate other than your residential address listed? ☐YES ☐NO

If yes, please list address(s) below:

_____

_____

I hereby state to the best of my knowledge and belief, the above stated information is true, correct and complete.

I understand that if any information has been falsely represented, this will be a sufficient cause for voiding this application for admission

*All of the information will be kept confidential by Oriol Health Care and will not be released without written permission.

Signature of Applicant (If able):_____Date: _____

Signature of Responsible Party: _____Date: _____

Application Check list: Please include the following documentation with this application:

☐ Completed application form

☐ Copies of applicant's insurance cards

☐ Copies of any of the following that apply:

- Power of Attorney
- Health Care Proxy
- Guardianship
- Conservatorship
- Trust

Please Mail, Email, Or Fax to one of the following:

Oriol Health Care, INc
Attn: **Admissions- LTC**
52 Boyden Road, Suite 209
Holden, MA 01520

Email: ltcapps@oriolhealthcare.com

Fax: 508-829-1277 (Attn: Admissions-LTC)

For Inquiries or assistance please contact: Kimberly Atwood
at 508-829-1140