RESPONSE REQUESTED

ST. PATRICK'S HOME FOR THE AGED AND INFIRM

66 Van Cortlandt Park South, Bronx, New York 10463

(718) 519-2800 Fax # 718-304-1817

ADMISSION APPLICATION

Name of Applicant: _____ *a/k/a:* _____

Maiden Name: _____

*Address*_____ *Home Phone* (_____) _____

_____

(City) (State) (County) (Zip Code)

Age: _____ *Date of Birth:* _____ *Place of Birth:* _____

Social Security # _____ *U.S. Citizen? Yes_ No*
PROOF OF CITIZENSHIP IS REQUIRED. If not, Legal Alien ☐ Illegal Alien ☐

Proof of Citizenship is required *by St. Patrick's Home.*

Number of years in New York State _____; *in New York City*_____?

*Father's Name:*_____ *Mother's Name:* _____

Education Level: _____

MARITAL STATUS

Married ☐ Single ☐ Separated☐ Divorced ☐ Widowed ☐

Name of Spouse: _____

Date of Marriage: _____ *If Deceased, date of death:* _____

Address: _____

Phone # (_____) _____ *Spouse's Social Security #*:_____

*Spouse's Occupation:*_____ Number of Children:_____

MILITARY INFORMATION

Are *you or any person in your family* a *Veteran? Yes ☐ No ☐; if so, who?:* _____

Veteran's Serial #: _____ *Branch of Service:* _____

Date of Service: _____ *Spouse's Veteran's #*: _____

APPLICANT'S EMPLOYMENT HISTORY

*Occupation:*_____ *Date of Retirement:* _____

Name & Address *of last* Employer: _____

Union Member? Yes ☐ No ☐ Name of Union: _____

PRIOR NURSING HOME PLACEMENT

Have you been in a nursing/rehabilitation facility and or hospital in the past year? If so,

Date of stay: _____ Facility Name: _____

Name of Hospital: _____

Revised: June 15, 2007

ADMISSIONS

SAINTPAIRICK'SHOME
66 Van Cortlandt Park South. Bronx. NY 10463

Tel. No. (718) 519-2800
Fax No. (718) 304-1817

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MEDICAL EMERGENCY INFORMATION

NAME OF RESIDENT: _____

It is vital that we have the Resident's contact information in the event of *an acute emergency. This information will be included in the Resident's file in the Social Service Department and the information is posted on the medical chart. Please advise the* ***Social Worker*** *and the* ***Charge Nurse*** of *any changes in addresses and telephone numbers.*

Please list contacts in the order of *accessibility and indicate all numbers where each can be reached:*

1. Name _____ Relationship _____

Address: _____

_____ Zip Code_____

Home Phone (_____) _____ Business Phone (_____) _____

Beeper/Cell Phone (_____) _____ E-mail address _____

2. Name _____ Relationship _____

Address: _____

_____ Zip Code_____

Home Phone (_____) _____ Business Phone (_____) _____

Beeper/Cell Phone (_____) _____ E-mail address _____

3. Name _____ Relationship _____

Address: _____

_____ Zip Code_____

Home Phone (_____) _____ Business Phone (_____) _____

Beeper/Cell Phone (_____) _____ E-mail address _____

If this is to be a *long-term* stay, *it is* necessary *for St. Patrick's* to *have the following information in the event* of *death:*

Funeral Parlor: _____ Phone #_____

Address: _____

Disposition of personal effects: Please check ☑ one:

☐ *To be removed (If so,* by *whom:* _____

☐ *To* be *discarded.*

FINANCIAL DISCLOSURE FORM FOR APPLICANT

BarCode

MEDICARE NO.:	OTHER INSURANCE NO. CARRIER NAME:
MEDICAID STATUS ☐Active ☐Pending: Date Applied _____ County Applied: Bronx	MEDICAID NO.: Effective Date:

	Applicant's Monthly Income	Spouse's Monthly Income
SOCIAL SECURITY	$	$
RAILROAD RETIREMENT	$	$
VETERAN'S BENEFIT	$	$
DIVIDENDS	$	$
PENSION	$	$

NAME OF COMPANY/UNION: _____

Employee I.D./File #:

DO YOU OWN YOUR OWN HOME? ☐Yes ☐No

Title is: ☐in my name ☐spouse's name ☐both names ☐other-if so, please list name and provide copy of deed:

(Name) _____ Relationship: _____

Value of Home: $_____ Amount of average monthly utility bills: $_____

If rental, monthly rent: $_____

DO YOU OWN A LIFE INSURANCE POLICY? ☐Yes ☐No Face Value $_____

Company Name: _____ Beneficiary: _____

APPLICANT'S BANK ACCOUNTS (Please use reverse side for additional information)

Name of Bank, address, zip code and phone #	Type of Account	Ownership of Account	Amount
		☐Self ☐Spouse ☐Joint	$
		☐Self ☐Spouse ☐Joint	$
		☐Self ☐Spouse ☐Joint	$
		☐Self ☐Spouse ☐Joint	$

STOCKS AND BONDS (Please use reverse side for additional information)

Name of Company	Number of Shares	Account Number	Approximate Value
			$
			$
			$
			$

Comments: _____

_____

Name of person completing this application: _____	Address: _____ _____
Today's date:_____	Phone #: _____

OUR ADMISSION POLICIES APPLY TO ALL RESIDENTS ADMITTED TO THE FACILITY WITHOUT REGARD TO RACE, COLOR, CREED, NATIONAL ORIGIN, AGE, SEX, RELIGION, HANDICAP, ANCESTRY, MARITAL OR VETERAN STATUS, AND/OR PAYMENT SOURCE.