

## St. Patrick's Residence

Nursing and Rehabilitation Served by the Carmelite Sisters for the Aged and Infirm "The Difference is Love"  $^{\rm NM}$ 

Date:	,	, ,	/

### Admission Application

Personal I	niormation
Name:	
(First) (Middle)	(Last)
Preferred Name:	Race:
Gender:	Religion:
Date of Birth (Mo., Day, Year): Age:	Marital Status:
	If Married, Name of Spouse:
	Language:
Telephone Number: ( )	Previous Occupation:
Address:	Mother's Maiden Name:
City:	Military Service:
State: Zipcode: County:	
Who referred you to St. Patrick's Residence?	
Insurance	Information
Social Security Number:	Medicaid Recipient Number:
Medicare Number:	Medicare Part D: ☐ Yes ☐ No
	Medicare Part D Number:
Life Insurance Company Name(s):	Policy Number(s):
Amount(s):	Premium(s):
Medical Insurance Company (other than Medicare):	ID Number:
	Group Number:

Medical Status				
Physician:	Address:	Da	te of Last Exam:	
Place of Last Skilled Nursing Facility:		Location:	Date:	
Tidoo of East Skilled Harding Facility.		Loodion.	Bato.	
			_	
Place of Last Hospital Admission:		Location:	Date:	
Reason for Admission:				
Previous Psychiatric Care:  uges	☐ no	Location:	Date:	
Reason for Psychiatric Care:				
,				
Substance Abuse Problems:  uges	□ no (If yes	, please explain)		
Date of Last Pneumonvax?		Date of Last Flu Shot:		
Allergies:				
Res	onsible Family	/ Members or Friends		
(In case of emergency, the			der they are listed.)	
Power of Attorney for Healthcare:				
Name:		Home Phone:		
Address:		Work Phone:		
City, State, Zipcode:		Cell Phone:		
Relationship:		E-mail:		
	liffarant from al			
Power of Attorney for Finances (if on Name:	illierent ironi ai	Home Phone:		
Address:		Work Phone:		
City, State, Zipcode:		Cell Phone:		
City, State, Zipcode.		Cell Filone.		
Relationship:		E-mail:		
Additional Contact:				
Name:		Home Phone:		
Address:		Work Phone:		
City, State, Zipcode:		Cell Phone:		
Relationship:		E-mail:		
Additional Contact:		L-IIIdii.		
Name:		Home Phone:		
Address:		Work Phone:		
City, State, Zipcode:		Cell Phone:		
Relationship:	D	E-mail:		
Burial Arrangements				
Funeral Home:		Address: City, State, Zipcode:		
Telephone Number:		ony, otate, zipodue.		

### Confidential (The following is for St. Patrick's Use Only and not for Public Knowledge) Financial Resources Please List: Monthly Income Source Amount Social Security Pension **Annuities** Other: Please List: **Checking Account** Bank Name **Amount** (If joint account, list all parties names) Please List: Savings Account Bank Name **Amount** (If joint account, list all parties names) Please List: Stocks, Bonds and Investments **Current Value** Company (If joint account, list all parties names) Please List: Real Estate **Current Value** Location (If joint account, list all parties names) Is there a mortgage on the property? ☐ Yes If so, what is the current amount of the mortgage: \_\_\_ Personal Property (List all assets of Resident, not listed above)

<sup>\*\*</sup> Please attach copies of most recent account statements. \*\*

# Power of Attorney (In the event that a resident, for any reason, becomes incapacitated)

Guardianship or Power of Attorney:	Relationship:			
Address:	( )			
(Street) (City, State,	Zipcode) Telephone Number			
Signature of Person who will assume financial responsibility for paying the bills and completing Medicaid application, if and when necessary:				
Print Name:	ignature:			
Please Read	and Sign Below			
I/We the undersigned hereby certify that the answers to the foregoing questions are true, correct and complete, that I/We have not knowingly or intentionally withheld any facts or circumstances which would, if disclosed, unfavorably affect the prospective Resident's application for admission. I/We hereby authorize a full investigation of any statement contained in this application by (Facility) or its agents. I/We understand that misrepresentation or omission of facts or information requested will be considered sufficient cause for denial of Resident's application for admission, or for immediate transfer or discharge of Resident from Facility.				
Signature of Applicant:	Signature of Responsible Party and/or Guardian:			
Signature of Witness:	Date:			
** SEE ATTACHED ADDENDUM **				



## St. Patrick's Residence

Nursing and Rehabilitation
Served by the Carmelite Sisters for the Aged and Infirm
"The Difference is Love" SM

#### Addendum to Admission Application

#### Income and Personal Resource Statement - Agreement and Undertaking

hereby represent to	Facility that, under the terms of a Power of Attorney for Property executed
oursuant to the Illinoi	s Power of Attorney Act (a copy of which I will deliver to Facility), I have access
to	(Name of Applicant) income and resources, which are available to
,	provides, and I have authority to execute this Agreement and Undertaking.
Accordingly, I agree	as follows:
4	

- 1. I understand that, under the terms of the Agreement to which this Addendum is attached, I am the Person who will assume financial responsibility for paying my Resident's bills and, when necessary, completing an application for Medicaid for him/her.
- 2. I affirm that the information I have provided Facility in the Admission Application is true and correct to the best of my knowledge.
- 3. I shall pay such income and resources, or funds I receive from Resident, to Facility when and to the extent needed for the payment for Resident's care at Facility;
- 4. I shall not use such income and resources for any purposes other than the foregoing or for Resident's benefit, during Resident's stay at Facility; and
- 5. I shall assign such income and resources to Facility at Facility's request to the extent necessary to pay for Resident's care at Facility.

This Agreement and Undertaking is limited to Resident's income and resources to which I have access and does not bind me to make any payment for Resident from my personal assets.

Signature of Resident or Responsible Party:	/
Print Name:	
Relationship to Resident:	