# St. Patrick's Residence

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

Date: ____/____/____

## Admission Application

| Personal Information |
|---|
| Name: |
| (First) (Middle) (Last) |

| | |
|---|---|
| Preferred Name: | Race: |
| Gender: | Religion: |
| Date of Birth (Mo., Day, Year): Age: | Marital Status:<br><br>If Married, Name of Spouse: |
| | Language: |
| Telephone Number: ( )<br><br>Address:<br><br>City:<br><br>State: Zipcode:<br>County: | Previous Occupation:<br><br>Mother's Maiden Name:<br><br>Military Service: |
| Who referred you to St. Patrick's Residence? | |

| Insurance Information | |
|---|---|
| Social Security Number: | Medicaid Recipient Number: |
| Medicare Number: | Medicare Part D: ❑ Yes ❑ No<br><br>Medicare Part D Number: |
| Life Insurance Company Name(s): | Policy Number(s): |
| Amount(s): | Premium(s): |
| Medical Insurance Company (other than Medicare): | ID Number:<br><br>Group Number: |

## Medical Status

Physician: Address: Date of Last Exam:

Place of Last Skilled Nursing Facility: Location: Date:

Place of Last Hospital Admission: Location: Date:
Reason for Admission:

Previous Psychiatric Care: ❑ yes ❑ no Location: Date:
Reason for Psychiatric Care:

Substance Abuse Problems: ❑ yes ❑ no (If yes, please explain)

Date of Last Pneumonvax? Date of Last Flu Shot:

Allergies:

## Responsible Family Members or Friends
(In case of emergency, these individuals will be contacted in the order they are listed.)

**Power of Attorney for Healthcare:**
Name: Home Phone:
Address: Work Phone:
City, State, Zipcode: Cell Phone:
Relationship: E-mail:

**Power of Attorney for Finances (if different from above):**
Name: Home Phone:
Address: Work Phone:
City, State, Zipcode: Cell Phone:
Relationship: E-mail:

**Additional Contact:**
Name: Home Phone:
Address: Work Phone:
City, State, Zipcode: Cell Phone:
Relationship: E-mail:

**Additional Contact:**
Name: Home Phone:
Address: Work Phone:
City, State, Zipcode: Cell Phone:
Relationship: E-mail:

## Burial Arrangements

Funeral Home: Address:
City, State, Zipcode:
Telephone Number:

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 (If joint account, list all parties names) | Bank Name | Amount |
|---|---|---|

Please List:

| Savings Account (If joint account, list all parties names) | Bank Name | Amount |
|---|---|---|

Please List:

| Stocks, Bonds and Investments (If joint account, list all parties names) | Company | Current Value |
|---|---|---|

Please List:

| Real Estate (If joint account, list all parties names) | Location | Current Value |
|---|---|---|

Is there a mortgage on the property? ❑ Yes ❑ No

If so, what is the current amount of the mortgage: _____

Personal Property
(List all assets of Resident, not listed above)

**** 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: Signature:

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 **

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# Addendum to Admission Application

## Income and Personal Resource Statement – Agreement and Undertaking

I hereby represent to Facility that, under the terms of a Power of Attorney for Property executed pursuant to the Illinois 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 pay for care Facility provides, and I have authority to execute this Agreement and Undertaking. Accordingly, I agree as follows:

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 Applicaton 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: _____ Date:____/____/____

Print Name: _____

Relationship to Resident: _____