St. Patrick's Residence

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

Date: ____/____/____

Short-Term Rehabilitation
Admission Application

Please note that if a resident transitions from Short-Term Rehabilitation to a Long Term Resident of St. Patrick's Residence, a full Admission Application must be completed at that time.

Personal Information
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: ( ) Address: City: State: Zipcode: County:	Previous Occupation: Mother's Maiden Name: 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 Medicare Part D Number:
Medical Insurance Company (other than Medicare):	ID Number: Group Number:

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:

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: