St. Camillus Health Center
Admissions Application for Long Term Care

Date:_____

Applicants Name: _____ Phone: _____

Current Address: _____ Date of Birth :_____

_____ Birth Place:_____

_____ Religion:_____

Marital Status:_____

First Contact Name: _____ Relationship:_____

Current Address: _____ Phone (H): _____

_____ Phone (W):_____

_____ Phone (C): _____

Heath Care Proxy: ____ Power of Attorney:_____ Email: _____

Second Contact Name: _____ Relationship:_____

Current Address: _____ Phone (H): _____

_____ Phone (W):_____

_____ Phone (C): _____

Heath Care Proxy: ____ Power of Attorney:_____ Email: _____

Third Contact Name: _____ Relationship:_____

Current Address: _____ Phone (H): _____

_____ Phone (W):_____

_____ Phone (C): _____

Heath Care Proxy: ____ Power of Attorney:_____ Email: _____

Social Security #:_____ Medicaid #:_____

Medicare#:_____ Part A:_____ Part B:_____

Medicare Supplemental Carrier :_____ Policy #:_____

Other Insurance Carriers:_____ Policy #:_____

Other Insurance Carriers:_____ Policy #:_____

Dates of Recent Hospital stays (last 30 days): _____

Hospital Name:_____ Admitting Diagnosis :_____

Primary Care Physician name:_____ Phone #:_____

Previous Skilled Nursing Facility Stay? Facility and dates:_____

Medical History:_____

_____

_____

List of Current Medications:_____

_____

_____

Is Applicant : (Circle all that apply)

Alert	Confused	Forgetful	Disoriented	Combative	Resistive
Oriented	Agitated	Depressed	Weepy	Wandering	

Is Applicant able to complete the activities listed below independently? (Circle all that apply)

Wash	Dress	Eat	Walk	Take care of toileting needs

List any assistive devices that the applicant currently uses:_____

Please give a brief description as to why you are looking into placement with St. Camillus at this time:

_____

_____

_____

Is there any additional information that would be helpful for us to know?

_____

_____

_____

FINANCIAL INFORMATION

(Please complete this entire page if the applicant does not have an active Medicaid number)

SECTION 1: Income

Social Security check amount:_____ Veteran's check amount:_____

Pension check amount:_____ Frequency received:_____

Pension check amount:_____ Frequency received:_____

Annuities received:_____ Frequency received:_____

Annuities received:_____ Frequency received:_____

Other Income :_____ Frequency received:_____

Please list any assets transferred by the applicant in the last 5 years:

Type of asset:_____Date transferred:_____ FMV:_____

Type of asset:_____Date transferred:_____ FMV:_____

Type of asset:_____Date transferred:_____ FMV:_____

SECTION 2: Real Estate

Does the applicant own a home:_____ Current Mortgage value of the home:_____

Names and relationship of other occupants in the home:_____

_____

Please list addresses of any other real estate that is owned (in whole or in part) by the applicant:

_____ _____ _____

_____ _____ _____

SECTION 3: Life Insurance

Active Life Insurance Policy Carrier:_____ Face value:_____

Carrier address:_____ Cash value:_____

_____ Policy number:_____

SECTION 4: Bank Accounts

Checking account bank name:_____ Account balance:_____

Savings account bank name: _____ Account balance:_____

IRA account held by: _____ Account balance:_____

Other Investments: _____ Account balance:_____

Other Investments: _____ Account balance:_____

Section 5: Funeral Arrangements:

Funeral Home Name:_____ Phone Number:_____

Address: _____