

**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: \_\_\_\_\_

# ADMISSIONS

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

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

## MEDICAL EMERGENCY INFORMATION

**RESPONSE  
REQUESTED**

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**

MEDICARE NO.:	OTHER INSURANCE NO. CARRIER NAME:																		
MEDICAID STATUS <input type="checkbox"/> Active <input type="checkbox"/> Pending: Date Applied _____ County Applied: Bronx	MEDICAID NO.: _____ Effective Date: _____																		
	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <th style="width:30%;"></th> <th style="width:35%;">Applicant's Monthly Income</th> <th style="width:35%;">Spouse's Monthly Income</th> </tr> <tr> <td>SOCIAL SECURITY</td> <td align="center">\$ _____</td> <td align="center">\$ _____</td> </tr> <tr> <td>RAILROAD RETIREMENT</td> <td align="center">\$ _____</td> <td align="center">\$ _____</td> </tr> <tr> <td>VETERAN'S BENEFIT</td> <td align="center">\$ _____</td> <td align="center">\$ _____</td> </tr> <tr> <td>DIVIDENDS</td> <td align="center">\$ _____</td> <td align="center">\$ _____</td> </tr> <tr> <td>PENSION</td> <td align="center">\$ _____</td> <td align="center">\$ _____</td> </tr> </table>		Applicant's Monthly Income	Spouse's Monthly Income	SOCIAL SECURITY	\$ _____	\$ _____	RAILROAD RETIREMENT	\$ _____	\$ _____	VETERAN'S BENEFIT	\$ _____	\$ _____	DIVIDENDS	\$ _____	\$ _____	PENSION	\$ _____	\$ _____
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DIVIDENDS	\$ _____	\$ _____																	
PENSION	\$ _____	\$ _____																	
NAME OF COMPANY/UNION: _____																			
Employee I.D./File #: _____																			
DO YOU OWN YOUR OWN HOME? <input type="checkbox"/> Yes <input type="checkbox"/> No Title is: <input type="checkbox"/> in my name <input type="checkbox"/> spouse's name <input type="checkbox"/> both names <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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
		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Joint	\$ _____
		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Joint	\$ _____
		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Joint	\$ _____
		<input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> 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.**