ADMISSION APPLICATION

ST. ANN'S HOME FOR THE AGED

198 Old Bergen Road
Jersey City, NJ 07305
Tel: 201-433-0950 • Fax: 201-604-2340
www.saintannshome.com

I. PATIENT INFORMATION

NAME	Last	First	Middle	Maiden
ADDRESS	Street	City	County	State / Zip Code

TELE. #	How Long at Above Address	Previous Address

Birthplace Date of Birth	Age	Marital Status ☐ Single ☐ Divorced ☐ Separated ☐ Married ☐ Widowed	Former Occupation

Religion	Parish	Diocese

Citizenship	Date of Immigration	Date of Naturalization	Language Spoken

Spouse's Name	Birthplace	Occupation

Last Date of Hospitalization	Length of Stay	Hospital Name

Cemetery	Funeral Director	Address

Responsible for Burial Do you have prepaid funeral arrangements?	Address

Who has deed of grave? (Please enclose a photocopy)

Has a Will been made? ☐ Yes ☐ No	Attorney's Name	Address

CONTACT IN CASE OF EMERGENCY: Relationship Tele. #

Name ______________________________

Address ______________________________ Bus. __________ Home ________

Name ______________________________

Address ______________________________ Bus. __________ Home ________

N.B. *THE NURSING HOME SERVICES ARE AVAILABLE TO ALL WITHOUT REGARDTO RACE, COLOR, RELIGION, CREED, NATIONAL ORIGIN, LIFESTYLE, OR HANDICAP.*

II. INSURANCE INFORMATION

1. Who has policy or policies?	2. Blue Cross & Blue Shield #	3. Medicare # and effective date
4. Medicaid # Effective Date	If currently Community Medicaid, you must re-submit Medicaid application for facility LTC approval	5. PAA Drug Card #
6. Case Worker		

	Insurance Company	Address
OTHER HEALTH INSURANCE	1.	
	2.	
LIFE INSURANCE	1.	
	2.	

III. FINANCIAL INFORMATION

Social Security #	Amt. Rec'd p/month	Pension - Name/Address	Amt. Rec'd. p/month

Other Assets	Amt. Rec'd p/month

RESPONSIBLE FOR BILLS ☐ Self ☐ Other Address

Name

Relationship to Patient	Home Tele. #	Bus Tele. #

Bank Accounts	Amount
1.	
2.	
3.	

IV. FINANCIAL STATEMENT

ASSETS	LIABILITIES
Cash on Hand	Notes Payable to Banks $
Cash in Banks	Notes Payable to Others
Notes Receivable	Accounts Payable
Accounts Receivable	Real Estate Mortgages
Loans Receivable	Real Estate Taxes
Life Insurance (Cash Surrender Value)	Loans against Life Insurance
Securities (Readily Marketable)	Federal & State Income Taxes

ASSETS	LIABILITIES
Securities (Not Readily Marketable)	Other Taxes
Mortgages Owned	Interest Payable
Real Estate	Other Liabilities
Automobile	
Other Assets	
	NET WORTH
TOTAL ASSETS	TOTAL LIABILITIES

- Resources at or below $20,000, must obtain Medicaid prescreening approval prior to admission.
- A copy of the Medicaid HSPD form with the Medicaid official letter of approval must be submitted prior to admission.
- If transferring from a LTCF to this facility, copy of Medicaid approval letter must be submitted prior to approval.
- Please keep all receipts of Medicaid/Social Security monies spent for one month prior to admission.
- We are a Medicare facility; some care is funded through Medicare benefits.

Name: ____________________

V. MEDICAL HISTORY

GENERAL INFORMATION (Please attach current EKG and Xray Reports.)

Applicant's Age: ________ Height: ________ Weight: ________

Blood Pressure: ________ Pulse: ________ Temperature: ________

Current Diagnoses: ____________________

____

____

ACTIVITIES OF DAILY LIVING

Ambulatory: ________ Walks with Assistance: ________ Uses Cane: ______ Walker: ______

Wheelchair: Self-propelling: ________ Needs Assistance: ________

Able to get in/out of wheelchair without assistance: ________ Needs Assistance: ________

Bed Status: Totally Bedridden: ________ Able to get in/out of bed without assistance: ________

Needs Assistance: ________ Requires lifting: ________ Requires turning: ________

Other: ____________________

Continence: Total Control: Bladder: ________ Bowel: ________

Urine Incontinence: Total: ________ Occasional: ________ Foley: ________

Onset: ____________________

Cause: ____________________

Intervention: ____________________

Bowel Incontinence: Total: ________ Occasional: ________ Colostomy: ________

Onset: ____________________

Cause: ____________________

Intervention: ____________________

Dietary: Able to feed self: ________ Requires Assistance: ________ NPO: ________

Special Diet Required: Yes: ______ No: ______ Type: ____________________

Tube Feeding: Yes: _____ No: ______ Type: ____________________

Dressing: Able to dress self: Total: _____ Partial: _____ Needs Assistance: _____

Unable to dress self: _____ Independent grooming: Yes: _____ No: _____

Assistive Devices: Eye Glasses: Yes: _____ Lens Implants: Yes: _____ Left: _____ Right: _____

Hearing Aid: Yes: _____ Left Ear: _____ Right Ear: _____

Dentures: Yes: _____ Upper: _____ Lower: _____

CURRENT MENTAL STATUS

Orientation: Fully Oriented: _____ Partially _____ Disoriented: _____
Memory: Short Term Memory Loss:_____ Long Term Memory Loss:_____
Behavior: Cooperative: _____ Depressed: _____ Noisy: _____ Combative: _____
Belligerent: _____ Resists Care: _____ Elopement/Wanderer: _____
Can make needs known: _____ Cannot make needs known: _____
Needs assistance in expressing thoughts: _____

Any Psychiatric Symptoms: ____________________

Past History of Psychiatric Disorder: ____________________

INFECTION CONTROL ASSESSMENT

Immunization History: Flu Shot: Yes: ____ No: ____ Date: __________
Pneumovax: Yes: ____ No: ____ Dates: __________
Hepatitis B: Yes: ____ No: ____ Doses: __________
T.B. Screening Results: Mantoux #1______ Mantoux #2 ______

Contagious Disease History: (Specify) ____________________

Presence of Invasive Devices: Type: __________ Date: __________
Type: __________ Date: __________

Presence of Decubitus, Stasis Ulcer, Wounds:

Type	Location	Stage	Treatment
1.			
2.			
3.			

Laboratory Findings: (Attach reports for CBC_____, Blood Chemistries_____ , Urinalysis _____ , and C&S (optional) _____ done within 90 days.)
MRSA Present: Yes: _____ No: _____ Site: __________
C-DIFF: Positive: _____ Negative: _____

CURRENT MEDICATIONS (Include Antibiotics and Chemotherapy)

Medication	Reason

Allergies: ____________________

CURRENT REHABILITATIVE THERAPY

Physical Therapy: _____ Occupational Therapy: _____ Speech Therapy: _____
Swallowing Therapy: _____ Mobility Training for the Blind: _____
Other: ____________________

OTHER TREATMENT MODALITIES

Ventilator Dependent: Yes: _____ No: _____ Tracheotomy: Yes: _____ No: _____
Peritoneal Dialysis: Yes: _____ No: _____ Hemodialysis: Yes: _____ No: _____
Total Parenteral Nutrition: Yes: _____ No: _____

PAST MEDICAL HISTORY

Treated by Dr. __________ For: __________ Date: __________
Treated by Dr. __________ For: __________ Date: __________
Hospitalized at __________ For: __________ Date: __________
Hospitalized at __________ For: __________ Date: __________

Other significant history: ____________________

If surgery is done, give description and dates: ____________________

Completed By: ____________________ Date: __________
Physician's Signature