APPLICATION FOR ADMISSION

This application is confidential. Please give complete replies, using separate sheets of paper if necessary.

MOUNT ALVERNO CENTER
Bon Secours Charity Health System
20 Grand Street, Warwick, NY10990
Phone: 845-986-2267 Fax: 845-986-3604
www.StAnthonyCommunityHosp.org

Family Information

1. Full Name _____

   Address _____

   _____ Social Security Number _____

2. Telephone Number _____ Date of Birth _____

3. Place of Birth _____

4. Are you married? _____ Single? _____ Divorced? _____ Widowed? _____

5. Name of husband or wife _____

   Address if living _____

6. Persons to contact in emergency:

   a. Name _____ Telephone # _____

      Address _____ Relationship _____

      _____

   b. Name _____ Telephone # _____

      Address _____ Relationship _____

      _____

   c. Name _____ Telephone # _____

      Address _____ Relationship _____

      _____

7. Present Location of Applicant _____

Personal Information

1. With whom are you living now? _____ Relationship _____

   Describe your situation (i.e. own home, rental, 3rd floor walk up apartment)

   _____

2. Your profession or occupation (previous, if retired) _____

   _____

3. Educational background_____

4. How did you hear about us? _____

5. Do you wish to remain active in your present religious group? _____

   If so, what is your religion? _____

6. What are your special interests? (hobbies, music, art, birds...)

   _____

   _____

   _____

7. Additional information about yourself that we should know _____

   _____

   _____

   _____

   _____

8. What are the major goals, skills or abilities you want to improve? _____

   _____

   _____

   _____

   _____

   _____

Health History

1. Give dates and nature of any major illness or operations you have experienced in the last ten years.

a.

Previous Illnesses/Surgery/Hospitalization	When	Previous Illnesses/Surgery/Hospitalization	When

Family History

b.

Hypertension	__ Yes	__ No	Cancer	__ Yes	__ No
Heart Disease	__ Yes	__ No	COPD	__ Yes	__ No
Epilepsy	__ Yes	__ No	TB	__ Yes	__ No
Diabetes	__ Yes	__ No	Other (specify) _____		

Medication History

c.

Name of Drug	Dose & Time/Freq	Last Dose Taken	Patient's Understanding of Medication

d. Present diagnosis _____

_____

2. Name of present physician _____

   Address _____ Telephone # _____

3. Have you ever been treated for any nervous or mental disorders? _____

   If yes, when? _____

   Name of physician who treated you? _____

   Address _____ Telephone # _____

4. Can you walk without assistance? _____

   If no, what kind of assistance to you need? _____

   _____

5. Can you completely care for yourself without assistance? _____ Bathe? _____

   Dress? _____ Use Restroom? _____

Financial Statement

1. **Monthly Income:**

Social Security	$ _____	List Pension Source & Amount
Veterans Benefits	$ _____	1. _____
R.R. Retirement	$ _____	1. _____
Dividends/Interest	$ _____	1. _____
Trust Income	$ _____	1. _____
Rental Income	$ _____	1. _____
Other	$ _____	1. _____

2. **Bank Accounts**

Name of Bank	Address	Acct#	Title of Acct	Balance

3. **Stocks and Bonds**

Name of Company	Number of Shares	Approximate Value

4. **Real Estate**

Location	Approximate Value

NOTE: Please provide documentation of the above financial information with this application.
All information on this application is CONFIDENTIAL.

5. **Life Insurance:**

Company	Type of Policy	Policy Number	Face Value	Cash Value	Beneficiary

6. **Any Other Assets Not Included Above:**

Description	Approximate Value

7. **List All Debts, Mortgages and Obligations:**

Payments Made To	Total Owed	Monthly Payments

8. **Health Insurance:**

Type	Policy#	Monthly Premium
Medicare A		
Medicare B		
Medicaid		
Blue Cross/Blue Shield		
Other (Name _____)		
Other (Name _____)		

Have you applied for Medicare? Yes _____ No _____ Date: _____

Medicaid? Yes _____ No _____ Date: _____

9. **Person Responsible for Payment of Bills - Financial Guardian - Power of Attorney:**

Name	Address	Telephone#	Relationship

I certify that the foregoing is a true and complete statement of my assets and liabilities and understand that **MOUNT ALVERNO CENTER** will act in reliance upon it.

I hereby authorize **MOUNT ALVERNO CENTER** to contact my financial references if necessary to verify the information contained in this statement.

I authorize **MOUNT ALVERNO CENTER** to pursue third party reimbursement and to make available such information of my medical and financial status as is appropriate.

MOUNT ALVERNO CENTER WILL NOT DISCRIMINATE AGAINST ANYONE ON THE BASIS OF RACE, CREED, SEX, SEXUAL PREFERENCE, AGE, DISABILITY, NATIONAL ORIGIN, RELIGION, MARITAL STATUS OR SOURCE OF PAYMENT.

Name _____

Signature _____

Date: _____

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