

Teresian House
Carmelite Sisters For the Aged and Infirm
200 Washington Avenue Extension
Albany, New York 12203-5394
Phone 518- 456-2000
Fax 518-724-2796

Reservation Date: _____
Date of Admission: _____
Admission No. _____
Room No. _____

FOR OFFICE USE ONLY

ADMISSION APPLICATION

Name _____ Maiden Name _____

Address _____
(Street) (City) (State) (Zip Code)

COUNTY: _____ Telephone: _____

Temporary Address (hospital, etc.) _____

Date of Birth _____ Age _____ Citizen? Yes ___ No ___ Hospital Preference: _____

Father's Name _____ Mother's Maiden Name _____

MARITAL STATUS: Single Married Divorced Separated Widowed

Spouse: Name _____ If living, where: _____
If deceased, date of death _____

Social Security # _____ Medicaid # _____ Veteran's # _____

Medicare # _____ Part A? Y ___ N ___ Part B? Y ___ N ___

Medicare Part D Plan?: Y N (Name of Plan): _____

Other Hospital Insurance _____

Please attach 1 copy (front&back) of Social Security, Medicare, Health Insurance & Prescription cards.

HEALTH CARE AGENT MUST BE LISTED AS FIRST CONTACT FOR EMERGENCIES AND HEALTH CARE DECISIONS (if one designated) When we are successful in reaching one person on the contact list we will not make any further calls, it will be the responsibility of the person contacted to call other family members. Please prioritize the order for contacts.

(Additional contacts should be listed on a separate page and attached)

1. Name _____ Address _____

Relationship _____ Home Telephone _____ Work Telephone _____

2. Name _____ Address _____

Relationship _____ Home Telephone _____ Work Telephone _____

3. Name _____ Address _____

Relationship _____ Home Telephone _____ Work Telephone _____

Attorney _____ Address _____

Home Telephone _____ Work Telephone _____

BURIAL ARRANGEMENTS:

Person responsible for burial arrangements: _____ Telephone _____

Funeral Director: _____ Telephone Number _____

Name: _____

WORK HISTORY: Former occupation _____ Date Retired _____

Last place of employment _____

FINANCIAL: (monthly)

Social Security Benefits \$ _____ Railroad Retirement \$ _____

Veteran's Benefits \$ _____ NYS Pension \$ _____

Other Pension \$ _____ From Whom? _____
Address _____

Annuity \$ _____ From Whom? _____
Address _____

Other Source of Income \$ _____ Specify _____

Do you own real estate? _____ Approximate value \$ _____

Do you own investments? _____ Approximate value\$ _____

Has there been a transfer of funds in past 3 years? Y N Date _____ Amount \$ _____

Name of Bank:	Address	Account No.	Present Balance
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List All Investment Accounts:	Policy No.	Cash Value
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Any other Insurance: _____

Do you have a Health Care Proxy or Living Will ? Yes ___ No ___ If yes, please attach a copy

Do you have a Power of Attorney? Yes ___ No ___ If yes, please attach a copy

Power of Attorney held by: _____ Address _____

To whom should **bills** be sent? _____ Address _____

To whom should **business mail** be sent? _____ Address _____

To whom should **personal mail** be sent? _____ Address _____

Name of Physician _____ Office telephone _____

Have you ever applied/been admitted to/ or denied admission by any other Institution or Home? _____

Name of Home: _____ Date _____

Reason for Leaving: _____

Why do you wish to live in Teresian House? _____

It is the policy of Teresian House that all available services are provided without regard to age, sex, race, color, ancestry, national origin, religious creed, handicap, or disability, sponsor, or sexual preference.

Date of Application _____ **Signature** _____

Responsible person _____ **Referred by** _____