

Teresian House
Carmelite Sisters For the Aged and Infirm
200 Washington Avenue Extension
Albany, New York 12203-5394
(518) 456-2000

**SCHEDULED SHORT TERM CARE
ADMISSION APPLICATION**

Name _____ Maiden Name _____

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

County _____ Telephone _____

Temporary address (if applicable) _____

Date of Birth _____ Age _____ Citizen? Yes ___ No ___

MARITAL STATUS: Single Married Divorced Separated Widowed

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

Social Security # _____ Medicare # _____ Medicaid# _____

Other Hospital Insurance _____

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

RESPONSIBLE PERSON AND/OR FAMILY CONTACTS (include zip codes)

(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 _____

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 _____

Person responsible for bills: _____ Address _____

Primary Physician: _____ Office telephone _____

Other Physicians: _____ Office telephone _____

Other Physicians: _____ Office telephone _____

Prior Hospitalizations (if any)

Date(s) _____ Location _____

Date(s) _____ Location _____

**** Note: if an acute emergency arises, Teresian House will transfer the resident to St. Peter's Hospital unless otherwise specified by your physician.**

Reason for needing scheduled short-term care stay _____

Has applicant stayed with us before? _____NO _____YES (When) _____

Dates requesting short-term stay: (certain regulatory restrictions may apply)

From: _____ To: _____

From: _____ To: _____

From: _____ To: _____

From: _____ To: _____

From: _____ To: _____

From: _____ To: _____

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 _____
(Applicant or responsible person)

Referred by: _____