St. Catherine of Siena Nursing and Rehabilitation Care Center
52 Route 25A
Smithtown, NY 11787
631-862-3900
(Fax) 631-862-3395

ADMISSION INFORMATON

Name____**Tel. No.**_________________________
Last First
Address___________________________________**City**_____________**State**__________**Zip**____________
County_________________ **How Long at this Address**___________________________
Previous Address_____________________________**City**_____________**State**_________**Zip**___________
Date of Birth___________________**Birthplace**_____________________________**Age**_______**Sex**_______
Citizen____**Yes**___**No** **Alien registration Number**___________________________________
Soc.Sec.No._____________________**Medicare No.**____________________________**Suffix** __________
Medicaid#:________________**Secondary Ins.**_____________________**HMO** ______________________
Applying for Medicaid, date applied_______ **Case Worker** _________________**Phone #**____________________
Attorney name and #____
Former Occupation___________________________ **Religion** _______________________

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Is the Applicant in the Hospital__________ **Nursing Home** ________ **Adult Home** ________ **Home** __________
Name of Facility____**Phone #**_________________________
Address of Facility ____ **Date of Admission**_______________
Applicant's Attending Physician______________________________ **Phone #**______________________
Is Short Term or Long Term Care being sought?________________________________

Marital Status_____________________ **Spouse's first Name**______________________
If spouse is living, Address___________________________________**City**______________**State** __________
Spouse's Date of Birth____________________________ **Spouse's Soc Sec. No.**________________________
U.S. Armed Forces Applicant ___**Yes** ___**No** **Spouse** ___**Yes** ___**No**

DESIGNATED RESPRESENTATIVE: Responsible Person
Name____ **Relationship**_____________________________
Address______________________________________ **Tel. (Home)**_____________________________
_____________________________**Zip**________ **Tel. (Work)**_____________________________
E-Mail____**Tel. (Cell)**_____________________________

ALTERNATE DESIGNATED RESPRESENTATIVE
Name____ **Relationship**_____________________________
Address______________________________________ **Tel. (Home)**_____________________________
_____________________________**Zip**________ **Tel. (Work)**_____________________________
E-Mail____**Tel. (Cell)**_____________________________

Advanced Directive: HCP____ **POA**___ **Living Will**___ **DNR**___
Any Home Care Services:____

Circle all that apply: Recent Falls Wandering Restless Smoker Alcohol Use
Alert Oriented Follows Directions

Signature of Applicant/ responsible Person________________________________**Date**________________

St. Catherine of Siena NH prohibits discrimination based on race, color, creed, national origin, sex, sexual preference, age, handicap, marital or veteran status, or source of payment as contained in NY State and Federal law.

St. Catherine of Siena Nursing Home
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Smithtown, NY 11787

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FINANCIAL INFORMATION

Applicants Name________________________ **Date** ____________
Medicare No.(if applicable):____________________ **Suffix** ____________
Blue Cross SNF Coverage ___Yes ___No Supplemental ___Yes ___No
Group Contract No.____________________ **Certificate No.** ____________
Policy Holder's Name____________________ **Effective Date** ____________
Does applicant have any other Long Term Care Insurance? ___ Yes ___No
If Yes, Name of Insurance Co. ____________________ **Group** ____________
Address____________________ **Policy No.** ____________
Name of Prescription Plan Coverage ____________________

Has MEDICAID been applied for? ___ Yes ___No Type :____Community ___ Chronic Care
Name of Worker ____________ **County**____________ **Tel No.**____________
Medicaid No. ____________ **Seq.**____________**Date of Approval** ____________

If other Hospital Insurance, Please complete the following:
Name of Insurance Co.____________________ **Group**____________
Address____________________ **Policy No.** ____________

Will patient/ resident pay privately? ___ Yes ___No If yes, amount available____________
Social Sec./ Railroad Benefits $ ____________ **Veteran's Benefits $** ____________
Pension Benefit $ ____________ **Company Name of Pension** ____________
Any Other Source of Income? Annuities ____ Stocks_____ Bonds _____ Dividends ____ Other ____
If Yes, give source and monthly dividend for each ____________________

____

If Jointly Owned: Name/ Address/ Tel No. of Joint Owner ____________________

		Name of Bank	Amount	Account No.
Checking:	**Joint ___Yes___No**			
Savings:	**Joint ___Yes___No**			
CD's:	**Joint ___Yes___No**			
Trusts:	**Joint ___Yes___No**			
Money Mkt:	**Joint ___Yes___No**			

Name/Address/Tel No. of Joint Owner______________________
Who holds Bank Books? Name:____________ **Address**____________
Does Applicant own property? (House Condo, Etc) Location ____________ **Value**____________
Joint Owner's Name____________ **Address**____________
Has there been any transfer of funds or property within the past 36 months? ____Yes ____ No
If yes, please explain ____________________
Does Applicant receive rental income? ___ Yes ___No Amount $ ____________

LIFE INSRUANCE POLICIES

Company of Society	Policy No.	Cash Value	Beneficiary

LEGAL AUTHORIZATION

Power of Attorney: Name ____________________
Guardian (If Applicable) ____________________
Who is responsible for paying monthly bills on the first of each month?
Name____________________ **Relationship**____________
Address____________________

Signature of Applicant/ Responsible Person____________________ **Date**____________

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