



St. Patrick's Manor
 863 Central Street
 Framingham, MA 01701-4892
 Tel. (508) 879-8000
 Fax (508) 626-1604

Date _____

Social Security # _____

Medicare # _____

Medex I, II or III # _____

Other Insurance _____

Medicaid # _____

Mass Health # _____

LTC Screening: Yes _____ No _____
 (If yes, please provide copy)

Father's Name _____

Mother's Maiden Name _____

APPLICATION FOR ADMISSION

****PLEASE PRINT****

Name _____

Address _____

Telephone () _____

Date of Birth _____ Age _____

Birthplace _____ Citizen _____

Religion _____ Marital Status _____

Spouse _____

If deceased, date of death _____

WORK HISTORY, PREVIOUS OCCUPATION

Previous Occupation (Work done during most of working life, even if retired) _____

Education Level _____

Primary Language _____

Were you in U.S. Armed Forces _____ Dates of Service _____

RESPONSIBLE PERSON (in planning and decision making for applicants care)

Name _____ Relationship _____

Address _____ City _____ State _____ Zip Code _____

Tel: (Home) _____ (Business) _____ (Cell) _____

Is there a health care proxy? _____ If yes, provide copy.

FINANCIAL MANAGER

Name _____ Relationship _____

Address _____ City _____ State _____ Zip Code _____

Telephone (Home) _____ (Business) _____

Is there Power of Attorney? _____ If yes, provide copy.

CURRENT STATUS OF APPLICANT

Applicant is now at: _____

Address _____ City _____ State _____ Zip Code _____

Contact Person _____ Telephone _____

Physician _____ Telephone _____

Address _____ City _____ State _____ Zip Code _____

Medical Diagnoses _____

Allergies _____

Mental Status _____

FINANCIAL INFORMATION

A. SOURCES OF INCOME:

Recipient's Name	Monthly Amount
Social Security _____	\$ _____
Retirement/Pension _____	\$ _____
V.A. Pension _____	\$ _____
Rental Income _____	\$ _____
Annuities/Investments _____	\$ _____
Other (Specify) _____	\$ _____

B. ASSETS:

Name of Bank	Type of Account	Value
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you own: Stocks _____ Bonds _____ CD's _____ Mutual Funds _____

Approximate Value _____

Insurance Company _____

Policy Number _____

Face Value _____

Have you created a trust or transferred assets? Yes _____ No _____

Explain _____

(copy of trust Instrument requested)

Do you own your home? Yes _____ No _____ Live Alone? Yes _____ No _____

Do you have Long Term Care Insurance? Yes _____ No _____

Company _____ Policy Number _____

Address _____ Telephone # _____

EMERGENCY NOTIFICATION

Name	Complete Address	Relationship	Tel.# (Home/Work)
1. _____	_____	_____	_____
2. _____	_____	_____	_____

BURIAL ARRANGEMENTS

Funeral Home _____

Address _____ Telephone _____

* I hereby state that to the best of my knowledge and belief, the above stated information is true, correct and complete. All of the information will be kept confidential by St. Patrick's Manor, and will not be released without my written permission.

Signature of Applicant _____ Date _____

Signature of Responsible Party _____ Date _____



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Date _____
 Physician _____
 Address _____
 Telephone _____

MEDICAL REPORT FOR ADMISSION

PLEASE TYPE OR PRINT

Name of Applicant _____ Age _____
 Address _____

Diagnosis (All Systems) _____

Present Medication _____

Previous Medical or Surgical History _____

Pneumovax: No Yes Date: _____ Tetanus / Diptheria No Yes Date: _____
 vaccine: _____

Allergies _____ Influenza Vaccine No Yes Date: _____

Is special diet required? _____ If so, please give details _____

Chief Complaints _____

PLEASE ANSWER IN DETAIL PHYSICAL EXAMINATION

General Condition	Ambulatory	Wheelchair	Bedridden
Skin	Thyroid	Height	Weight
Vision		Hearing	
Teeth		Speech	
Lungs		Blood	Urine
Abdomen	Genito-Urinary	Incontinence	Bowel
			Bladder

Does applicant have any physical disabilities? Please state fully. _____

Does applicant have any mental impairments? Please describe in detail whether or not applicant is alert, forgetful, noisy, cooperative, and list any peculiarities in behavior. _____

 Physician's Signature