



**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 decisions in applicants care)**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Telephone (Home) \_\_\_\_\_ (Business) \_\_\_\_\_

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 \_\_\_\_\_ Do you smoke? Yes \_\_\_\_\_ No \_\_\_\_\_

Will Physician attend here? Yes \_\_\_\_\_ No \_\_\_\_\_

**FINANCIAL INFORMATION**

**A. SOURCES OF INCOME:**

Recipients 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 (since 1990) or transferred assets (in the last 36 months)? 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. \_\_\_\_\_