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 the past 60 months? Y N Date_____Amount$_____
Has a trust been established? Yes_____ No_____ Year established_____
Types of Trust_____ Please provide a copy of the trust.

Name of Bank: **Address** **Account No.** **Present Balance**

_____

_____

_____

List All Investment Accounts: **Policy No.** **Cash Value**

_____

_____

_____

Any other Insurance: _____
_____

Do you have a Health Care Proxy Yes __ No __ Living **Will** Yes__No__ **M.O.L.S.T.** Yes__ No__
If yes, please attach a copy of all documents
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** _____