TERESIAN HOUSE

Where the spirit of love and dedication lives...

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.): _____

DOB:_____ 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 Number: _____

   Work Number:_____ Cell Number: _____

2. Name: _____ Address:_____

Relationship: _____ Home Number: _____

Work Number:_____ Cell Number: _____

3. Name: _____ Address:_____

Relationship: _____ Home Number: _____

Work Number:_____ Cell Number: _____

Attorney _____Address _____

Home Telephone _____ Work Telephone _____

BURIAL ARRANGEMENTS:
Person responsible for burial arrangements: _____Telephone:_____

Funeral Directo _____ r: _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? _____ Year the trust was established_____

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: _____