Dear Prospective Resident and/or Family:

Thank you for your inquiry about St. Joseph's Senior Home. I have enclosed an application that must be completed in full and returned to the facility for consideration for admission to either our Assisted Living or Nursing Center. A non-refundable fifty-dollar ($50.00) application fee must accompany the completed application when it is returned to us.

Return the completed application promptly so that our Admission Committee can review it for approval. It may be necessary for the prospective resident to be interviewed or evaluated in person prior to approval being rendered. You will be contacted, as will the sending facility where applicable, if additional information is necessary to thoroughly assess the resident for possible admission. Once approved, if there is an available bed, admission will be scheduled.

If a room is not available, the applicant's name shall be placed on the waiting list in the order that it is received. He or she will be notified once a room becomes available in the area for which the application is being made and is appropriate to meet individual needs.

Please be sure to complete the application in its entirety and have your attending physician and the hospital or other facility provide all necessary medical information to assist the committee in evaluating the prospective resident's specific needs.

All financial information, as well as proof of any legal authorizations must be provided at the time of application. Should the application be incomplete when submitted, you will be notified of information that is lacking and the application will not be evaluated by the Committee until all necessary information is received.

The content of the application shall remain confidential and is utilized for the sole purpose of evaluating the prospective resident's status for admission.

Note: Charges to be incurred are for basic services in Assisted Living. Additional services are provided at additional cost dependent upon individual needs as assessed by our health care team. Each resident upon admission will be assessed. This assessment will again be completed when a physical or mental status change of condition occurs to ensure that all needs are being met. Charges in the Nursing Center reflect skilled nursing care needs and are charged accordingly to private pay, Medicare or Medicaid as applicable.

Sincerely yours;

Sister Elzbieta Lopatka, LNHA
Administrator

Sister Zdzislawa Krukowska, CALA, LNHA
Assisted Living Administrator

Approval Date :_____

Application Received:_____

Date of Application:_____

A: APPLICATION FORM

1. Name _____Age_____Admission_____
   Last First Middle
2. Present Address _____Tel:_____
3. Social Security #_____ Spouse's Social Security#_____

   Medicare #_____Medicaid # _____
4. Former Occupation_____ Spouse's Occupation_____
5. Date of Birth_____ Birthplace_____
6. Father's Full Name_____ Mother's Maiden Name_____
7. Current Marital Status: Married____ Single____ Widowed____ Divorced_____ Separated_____
8. Date of Marriage_____Name of Spouse or Former Spouse _____
9. Religious affiliation_____Deceased_____
10. Number of Children:

a)_____
Name Age Address Home Tel. #

_____
Occupation Place of Employment Bus. Tel .#

b)_____
Name Age Address Home Tel. #

_____
Occupation Place of Employment Bus. Tel. #

c) _____

Name Age Address Home Tel. #

_____

Occupation Place of Employment Bus. Tel #

11. Person to notify in case of emergency:

a) Name_____Relationship_____

Address_____Home Tel#_____Bus Tel#_____

b) Name_____Relationship_____

Address_____Home Tel#_____Bus Tel#_____

12. How long in U.S? _____in New Jersey?_____

13. Citizen ☐ YES ☐ NO Certificate # _____

14 Alien Registration # _____

15 Veteran ☐ YES ☐ NO Which war? _____

16. Serial # _____ Claim # _____

17. Education: Last school grade completed:

8th ☐ 12th ☐ College ☐ Graduate Degree _____

18. Do you have any coverage for hospital and medical expenses? ☐ YES ☐ NO

19 Blue Cross _____ Blue Shield _____

20. Group # _____ Certificate _____

Other Health Insurance _____

_____

21 Medicare # _____ Part A _____ Part B _____

22. Have you any life insurance? YES ☐ NO ☐

_____

Company Policy # Type Date issued

FINANCIAL INFORMATION

Does Resident have any insurance coverage? YES ☐ NO ☐

Name of Insurance Company _____

Address : _____Tel : _____

Policy # _____Type of Policy _____

Is patient payment source through welfare? No ☐ Yes ☐ If Yes, County Board of Social Services:

_____Caseworker _____

Social Security # _____Amount $ _____

Social Security Check is currently Direct Deposit to Bank ☐ Goes to Resident Address ☐ Other ☐

VA Pension? YES ☐ NO ☐ Amount :_____ Goes where? _____

Does Resident receive a pension? YES ☐ NO ☐ Amount $ _____

Name of company pension comes from : _____

Address : _____Tel : _____

Pension is on a : Monthly ☐ Quarterly ☐ Bi-yearly ☐ Other _____

Does Resident own any property? YES ☐ NO ☐ Is it expected to be sold? YES ☐ NO ☐

Address of property _____
Attach copy of deed(s)

Is spouse living at above address at this time? _____

IF THERE IS A POWER-OF-ATTORNEY, PLEASE COMPLETE THE FOLLOWING

Is there a Power-Of-Attorney? ☐ YES ☐ NO If YES, circle type(s) that apply and attach copy of Power -Of-Attorney (s).

* Bank POA* * Financial POA* * Medical POA*

Does Resident have a Pharmaceutical Assistance To the Aged (PAAD) card? ☐ YES ☐ NO

If YES, what is PAAD number? _____

MISCELLANEOUS CURRENT INFORMATION

Resident's stay at St. Joseph's Senior Home is intended to be

☐ Respite/ short term ☐ Long Term ☐ Unsure at this time

Expected length of stay _____ number of weeks

Where is prospective Resident now? _____

Is there a Social Worker? ☐ NO ☐ YES, Name_____ Tel : _____

If Resident is in a hospital, nursing home, etc., when was he/she admitted and primary reason for admission :

Date : _____Reason : _____

Expected date of discharge, if known _____

Was Resident in a nursing facility in the past? ☐ NO ☐ YES, _____

_____(name) Date ____/____/____/ to ____/____/____

SHORT TERM AND RESPITE APPLICANTS COMPLETE THIS SECTION

In the event the Resident improves sufficiently to be discharged, the tentative plan is that the Resident be moved to :

Own Home ☐ Senior Citizen Apartment ☐ Boarding Home ☐ Home of family member Name _____ ☐ No plan ☐

How does Resident feel about the plan? _____

SOCIAL HISTORY

RESIDENT'S BACKGROUND

Place of Birth:_____ Nationality/Ethnic Background_____

If foreign born, year came to USA_____ US Citizen now? NO ☐ YES ☐ Year _____

Does Resident speak any foreign language (s)? ☐ NO ☐ YES _____

Please indicate: Resident can ☐ Understand ☐ Speak ☐ Write English

If Resident does not speak or understand English, how will he/she make needs known?

_____

Religion _____ Resident's own clergy person is encouraged and welcome to visit, if desired

Occupation : _____

What are some of the Resident's hobbies or interests (even if physically unable to do now) :

_____

_____

Resident belongs or belonged to the following clubs :_____

_____

Any military experience ☐ NO ☐ YES, Type and location _____

Branch of military _____

Did/does Resident have any pets? ☐ NO ☐ YES, type,(s) _____

Any travel (s) ? ☐ NO ☐ YES, Where _____

Does Resident smoke? ☐ NO ☐ YES, # of packs per day _____

Living Arrangements :

Where did Resident live prior to coming to St. Joseph's Senior Home?

Apartment ☐ Apartment will be held for _____ months Is it handicapped or

☐ Apartment was given up Specially designed? ☐ YES ☐ NO

Senior Citizen's Apartment ☐ Apartment will be held for _____months

☐ Apartment was given up

Home of daughter or son: State name of child Resident lived with _____

Resident's own home ☐ rented will hold for _____months. ☐ Home will be sold.

Was a Home Health Aid or Homemaker coming in? ☐ YES ☐ NO Was aide a live-in? YES ☐ NO ☐

If yes, _____days per week Hours per day _____

What has Resident been told about his/her condition and the outlook for the future?

_____

_____

What was the Resident's reaction? _____

Any special goals, ambitions or hopes? _____

MARITAL HISTORY

Current Status: Never Married ☐ Divorced ☐ Separated ☐ Widowed ☐

First Marriage

Spouse's name _____

Year marriage ended _____

Due to : Divorce ☐ Death ☐ Separation ☐

Reaction to end of marriage _____

_____

Any children: NO ☐ YES, # _____

Name (s) of children:

_____

_____

_____

Second Marriage

Spouse's name _____

Year marriage ended _____

Due to : Divorce ☐ Death ☐ Separation ☐

Reaction to end of marriage _____

_____

Any children? NO ☐ YES, # _____

Name (s) of children:

_____

_____

_____

LIVING WILL/ADVANCE DIRECTIVE FOR HEALTH CARE

In New Jersey, competent persons entering a health care facility have the right to complete and set forth his/her wishes for health care. In the event that he/she subsequently loses decision making capacity. That is a " Living Will " (Advance Directive). A "Proxy Directive" is commonly known as a Durable Power-of-Attorney for health care. This designates a health care representative to make health care decisions on Resident 's behalf, in the event that the Resident loses decision making capacity. Both documents or a combination of both must be signed by the person and witnessed by two witnesses. Documents can be modified or revoked at any time. If you need more information or would like to complete either of the above, please see our Social Services Director.

At this time, prior to admission, we are asking if the Resident currently has either a Living Will, Advance Directive or Power-of-Attorney for health care.

(Please be advised that St. Joseph's Senior Home had a policy that allows for the provision of basic nutrients and fluids at all times during care provision).

ADDITIONAL INFORMATION

Please check if Resident owns any of the following:

☐ Wheelchair ☐ Geri-chair ☐ Cane ☐ Walker

FOR THE RESIDENT'S MEDICAL CHART

Name of responsible party for Resident :_____Relationship _____

Address _____

Home Phone _____Work phone _____

The responsible party's name would be listed first as the person to contact in case of emergency. If the above person cannot be reached, please list an alternate person to reach.

Alternate Party _____ Relationship _____

Address _____

Home phone _____Work phone _____

For the medical chart, we also need to list a funeral home in the event of death. Please fill in below:

Name of funeral home _____

Address _____

Telephone _____Is funeral prepaid? YES☐ No☐

Any comments or concerns _____

Signature of Responsible party _____**Date** _____

THANK YOU FOR YOUR INTEREST IN ST. JOSEPH'S SENIOR HOME

If you have any questions, or need any assistance in filling out this application, please feel free to contact the Admission Department.

ST. JOSEPH'S SENIOR HOME

FINANCIAL INFORMATION DISCLOSURE

Please use this form to give us an accurate accounting of the applicant's financial status. This information is necessary to determine the resources of the applicant in relation to the cost of the nursing home care. No application for admission to St. Joseph's will be considered unless this Disclosure, completed and properly executed, is received.

Please provide us with the following information and include copies of bank statements where applicable to verify the information given.

Name of Applicant : _____

Date of Birth : _____ SSN : _____

Monthly Income : Social Security: $ _____

Supplemental Security Income (SSI) $ _____

Spouse's Social Security $ _____

Disability-specify type $ _____

Pension-specify type $ _____

Interest, rentals, dividends, etc. $ _____

BANKING INFORMATION
Checking account

Name on Account : _____

Bank : _____ Current Balance : $_____

Name on Account :_____

Bank : _____ Current Balance : $ _____

Savings Account :

Name on Account : _____

Bank : _____ Current Balance : $ _____

Name on Account : _____

Bank : _____ Current Balance : $ _____

CD Account :

Name on Account : _____

Bank : _____ Current Balance : $ _____

Name on Account : _____

Bank : _____ Current Balance $ _____

Other Accounts : _____

Stocks/ Bonds: Estimated Value : $ _____

Dividend/Interest : $ _____

Real Estate: Please specify name or names on deed (s) : _____

Market Value of Home (s) : $ _____

Type of Property :_____

Address of property : _____

_____

Balance on Mortgage :_____$ _____

Rental Income (If Any) : $_____

Please specify name or names on deed (s) : _____

Market Value of Home (s) : $ _____

Type of Property : _____

Address of Property : _____

_____

Balance on Mortgage_____

Rental Income (If any) _____

Have you transferred any assets in the past 5 years? YES _____ NO _____

If the answer to the above question is yes, please identify to whom assets were transferred. If assets were transferred to a trust, please provide the name the trust and the name and telephone number of the trustee.

_____

_____

INSURANCE POLICIES :

Life Insurance : Name of Insurance Company (ies) :_____

_____

Proceeds : $ _____

Cash Value : $_____

Health Insurance : Name of Insurance Company :
_____

Policy Number : _____

Name of Insurance Company : _____

Policy Number : _____

Medicare : Medicare # : _____

Is the applicant covered for part A? _____

Is the Applicant covered for part B? _____

Does the applicant have Medicaid? If yes, please provide:.

Medicaid # _____

Date of Eligibility : _____

Is there a Financial Power of Attorney for applicant? If yes, please attach a copy of the Power Of

Attorney to this Disclosure. YES ☐ NO ☐

Person responsible for allocating applicant's funds :

Name : _____

Address : _____

_____

Phone : Home : _____

Work : _____

CERTIFICATION :

This is to certify that all statements herein and any supporting schedules are true to the best of the undersigned's knowledge, information, and belief and these documents give a true and correct showing of the financial condition of the applicant. I further certify that the assets set forth are solely in the applicant's name except as otherwise noted on this disclosure. The resources and assets which are identified above will be utilized to pay St. Joseph's Senior Home for the care of the applicant.

Signature of Responsible Party
or duly appointed Attorney-in-fact : _____

Date : _____

_____

_____

FOR OFFICE USE ONLY :

Date Received : _____

Approved By : _____

_____

St. Joseph's Senior Home
Assisted Living

PROSPECTIVE RESIDENT'S PRE-ADMISSION PHYSICAL EXAM

I have examined _____ on_____and submit the
First Name Last Name Date
following report:_____

Complete diagnosis _____

_____

Nature and date of any recent surgery: None☐ If yes _____

_____

What is patient's prognosis? _____

Any abnormal physical findings?_____

GENERAL PHYSICAL CONDITION

Circle : Incontinent of bowel and/ or bladder ☐ Continent ☐

Ambulates :☐ Independently ☐ With Assistance☐ Unsteady Gait☐ Bedridden ☐

Site(s) of decubitus, if any _____

Mental Health & Status : ☐ Alert☐ Confused☐ Depressed☐ Other_____

Any history of psychiatric disorder? ☐No / Yes☐ State _____

Ever admitted to psychiatric facility? ☐No☐ Yes, Name & Date _____

Please list the following :

MEDICATIONS & TREATMENT	INSTRUCTIONS FOR GENERAL NURSING CARE
_____	_____
_____	_____
_____	_____

Instructions for diet : _____

Any special precautions? _____

Is patient allergic to any food or medicine? _____NKA YES:_____

_____

Pneumovax: NO ☐ YES ☐ Date given:_____ Flu vaccine ☐ NO ☐ YES Date given: _____

Lab Work Report	EKG Report	Chest X-Ray Report
Date _____	Date _____	Date_____
Normal : YES ☐ NO ☐	Normal YES ☐ NO ☐	Normal : YES ☐ NO ☐
List Abnormalities :	List Abnormalities :	List Abnormalities :

PLEASE ATTACH COPIES OF ALL CURRENT LABORATORY OR DIAGNOSTIC REPORTS

Physician's Name _____ Tel # _____

Address _____

If patient is admitted to St. Joseph's Senior Home, will you be the attending? ☐ YES / NO ☐

PLEASE LIST ALL THE MEDICATIONS

_____

_____

Any allergies to any foods or medication? _____

When was the last time examined ? _____If within 6 months, please forward the records.

In New Jersey, when a person enters a long term care facility, they must be examined by a dentist within 6 months of admission.

Any reddened areas? (Please describe location (s)).

_____

_____

Does resident have any decubiti (bedsores)? ☐ NO YES ☐ AREA(S) ☐ NO YES ☐

Area (s) _____

_____

Is resident getting dressings? _☐_ YES NO _☐_ Area _____

Resident uses or has used Oxygen :

Rarely ☐ Sometimes ☐ Continuous ☐ While in hospital facility ☐

PHYSICAL ABILITIES

Height: _____inches Weigh: _____ lbs.

SPEECH: Normal ☐ Impaired ☐ Unable to speak ☐ Needs Speech Therapy ☐

HEARING: Normal ☐ Impaired ☐ Deaf ☐ Hearing Aids: Left Ear ☐ Right Ear ☐ Both ☐

SIGHT: Normal ☐ Impaired ☐ Blind: ☐ Left Eye ☐ Right Eye ☐ Wears Glasses ☐

MENTAL STATUS: Alert & Oriented ☐ Forgetful ☐ Slightly Confused ☐ Always Confused ☐

Psychiatric Background? ☐ YES NO ☐ Was resident ever admitted to a psychiatric hospital or treated for a psychiatric disorder? ☐ YES NO ☐

Explain _____:

Name of psychiatric hospital _____ Date ___/___/___/to ___/___/__/

EATING: Independent ☐ Needs Assistance ☐ Cannot Feed Self ☐ Gastrostomy Tube ☐

DRESSING: Independent ☐ Needs Assistance ☐ Cannot Dress Self ☐

ELIMINATION: Independent ☐ Assist to Bathroom ☐ Bedpan ☐ Catheter ☐

Incontinent of: Bowel ☐ Bladder ☐ Both ☐

AMBULATION: Independence ☐ Walks with Assistance Bed-bound ☐

Needs help from bed to chair: _____# of persons needed to assist

Resident Uses: Wheelchair ☐ Geri-chair ☐

Resident sits up in chair for _____ hours per day.

SLEEPING Usual bedtime is _____PM. Usually awakens at ____AM. If take times

I, _____M.D. certify that
(Physician's Name)

_____currently has no health care service
(Resident's Name)

needs and is appropriate for an Assisted Living Residence.

_____ _____
Physician Signature Date