St. Joseph's Senior Home
Assisted Living – Nursing Home
1-3 St. Joseph's Terrace, Woodbridge, NJ 07095
Tel: 732-750-0077 Fax: 732-634-1811

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

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Tel: 732-750-0077 Fax: 732-634-1811

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

St. Joseph's Senior Home
Nursing Center & 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

_______________________________ _______________________
Physician's signature Date

GENERAL MEDICAL INFORMATION

Instructions: Please complete as much as possible. If you are unsure of an item, leave it blank. Accurate and complete information will be contained in the physician's report(s).

Date of Birth _____/_____/_____ Age _____ Dentures: None Upper Lower Full-set

Diabetic? NO YES Type of diet ____

Resident uses: Check one or more, if appropriate: Cane, Quad-Cane, Walker, Wheelchair

Does Resident use prothesis? NO YES Type ____

What is the name of Resident's Physician?____

Office Address ____ Tel # _____________________________

What is the most recent diagnosis? ____

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

Restless ( ) Wanders at Night ( ) Regularly ( )

Daytime dozing ( ) Need side rails ( )

Unable to use nurse call bell ( )

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 : ____________________

____