

APPLICATION FOR ADMISSION



SCHERVIER PAVILION
Bon Secours Charity Health System
22 Van Duzer Place, Warwick, NY10990
Phone: 845-987-5717 Fax: 845-987-1398
www.StAnthonyCommunityHosp.org

This application is confidential. Please give complete replies,
using separate sheets of paper if necessary.

Family Information

1. Full Name _____

Address _____
Social Security Number _____

2. Telephone Number _____ Date of Birth _____

3. Place of Birth _____

4. Are you married? _____ Single? _____ Divorced? _____ Widowed? _____

5. Name of husband or wife _____

Address if living _____

6. Persons to contact in emergency:

a. Name _____ Telephone # _____
Address _____ Relationship _____

b. Name _____ Telephone # _____
Address _____ Relationship _____

c. Name _____ Telephone # _____
Address _____ Relationship _____

7. Present Location of Applicant _____

Personal Information

1. With whom are you living now? _____ Relationship _____

Describe your situation (i.e. own home, rental, 3rd floor walk up apartment)

2. Your profession or occupation (previous, if retired) _____

3. Educational background _____

4. How did you hear about us? _____

5. Do you wish to remain active in your present religious group? _____

If so, what is your religion? _____

6. What are your special interests? (hobbies, music, art, birds...)

7. Additional information about yourself that we should know _____

8. What are the major goals, skills or abilities you want to improve? _____

Health History

1. Give dates and nature of any major illness or operations you have experienced in the last ten years.

a.	Previous Illnesses/Surgery/Hospitalization	When	Previous Illnesses/Surgery/Hospitalization	When

Family History

Hypertension	___ Yes	___ No	Cancer	___ Yes	___ No
Heart Disease	___ Yes	___ No	COPD	___ Yes	___ No
Epilepsy	___ Yes	___ No	TB	___ Yes	___ No
Diabetes	___ Yes	___ No	Other (specify) _____		

Medication History

c.	Name of Drug	Dose & Time/Freq	Last Dose Taken	Patient's Understanding of Medication

d. Present diagnosis _____

2. Name of present physician _____
 Address _____ Telephone # _____

3. Have you ever been treated for any nervous or mental disorders? _____
 If yes, when? _____
 Name of physician who treated you? _____
 Address _____ Telephone # _____

4. Can you walk without assistance? _____
 If no, what kind of assistance to you need? _____

5. Can you completely care for yourself without assistance? _____ Bathe? _____
 Dress? _____ Use Restroom? _____

Financial Statement

1. Monthly Income:

Social Security	\$ _____	List Pension Source & Amount
Veterans Benefits	\$ _____	1. _____
R.R. Retirement	\$ _____	1. _____
Dividends/Interest	\$ _____	1. _____
Trust Income	\$ _____	1. _____
Rental Income	\$ _____	1. _____
Other	\$ _____	1. _____

2. Bank Accounts

<u>Name of Bank</u>	<u>Address</u>	<u>Acct#</u>	<u>Title of Acct</u>	<u>Balance</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. Stocks and Bonds

<u>Name of Company</u>	<u>Number of Shares</u>	<u>Approximate Value</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Real Estate

<u>Location</u>	<u>Approximate Value</u>
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

NOTE: Please provide documentation of the above financial information with this application.
All information on this application is CONFIDENTIAL.

5. **Life Insurance:**

<u>Company</u>	<u>Type of Policy</u>	<u>Policy Number</u>	<u>Face Value</u>	<u>Cash Value</u>	<u>Beneficiary</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

6. **Any Other Assets Not Included Above:**

<u>Description</u>	<u>Approximate Value</u>
_____	_____
_____	_____
_____	_____

7. **List All Debts, Mortgages and Obligations:**

<u>Payments Made To</u>	<u>Total Owed</u>	<u>Monthly Payments</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

8. **Health Insurance:**

<u>Type</u>	<u>Policy#</u>	<u>Monthly Premium</u>
Medicare A _____	_____	_____
Medicare B _____	_____	_____
Medicaid _____	_____	_____
Blue Cross/Blue Shield _____	_____	_____
Other (Name _____)	_____	_____
Other (Name _____)	_____	_____

Have you applied for Medicare? Yes _____ No _____ Date: _____
Medicaid? Yes _____ No _____ Date: _____

