

Providence Rest



Dear Applicant,

Thank you for your inquiry regarding admission to Providence Rest.

Enclosed you will find three (3) forms to be completed and returned to Providence Rest Home as soon as possible. They consist of an application, a Medical Report and Eye report. The medical report **MUST** be completed by your private physician and accompanied by a laboratory report and an EKG. You must also contact a local Visiting Nurse Service or Home Health Care Agency in order to obtain a PRI & Screen. These two forms are required by the New York State Health Department for admission to any nursing home.

A personal interview with our Social Service and /or Finance Department may be requested.

Should there be any questions, please feel free to call our office and ask for Rose Cicero at Ext. 8320.

Sincerely,
Rosemarie Hofstein, LMSW
Director of Social Service

3304 Waterbury Avenue Bronx, New York 10465 (718) 931-3000

Fax: Administration (718) 863-0185 Social Service (718) 514-8226

Website: providencerest.org

**PROVIDENCE REST NURSING HOME
3304 WATERBURY AVENUE
BRONX, NEW YORK 10465
718-931-3000**

APPLICATION FOR SNF ADMISSION: Thank you for inquiring about admission. In order to help you, we would appreciate your completing the following information and returning the FORM to us. All questions must be completed or the application will be returned. **THIS APPLICATION DOES NOT GUARANTEE ADMISSION.**

NAME: _____ **a/k/a/** _____ **DATE** _____

ADDRESS: _____ **PHONE:** _____

NAME OF AGENCY, HOSPITAL OR PERSON REFERRING _____ **TELEPHONE NUMBER** _____

ADDRESS: _____

REASON FOR APPLYING _____ **SOCIAL SECURITY NUMBER** _____

DATE OF BIRTH: _____ **PLACE OF BIRTH (City & Country)** _____

Education: Grammar School _____ High School _____ College _____

OTHER _____

Marital Status: Single _____ Married _____ Widowed _____ Separated _____

Divorced _____ **Number of times married** _____

U.S. Citizen _____ **Alien #** _____ **Naturalization #** _____ **How long in NY State/ Country** _____

SPOUSE'S NAME (MAIDEN) & OCCUPATION: _____ **SPOUSE'S S.S. #** _____

SPOUSE'S DATE OF BIRTH _____ **DATE DECEASED** _____

EMERGENCY/PRIMARY CONTACT _____ **RELATIONSHIP** _____ **HOME PHONE NUMBER** _____ **HEALTH CARE AGENT**
_____ **YES** _____ **NO** _____

ADDRESS _____ **BUSINESS #:** _____

_____ **CELL #** _____

FATHER'S NAME: _____ **DATE OF BIRTH:** _____ **PLACE BIRTH:** _____ **DATE DECEASED** _____

MOTHER'S MAIDEN NAME _____ **DATE OF BIRTH** _____ **PLACE BIRTH** _____ **DATE DECEASED** _____

POWER OF ATTORNEY: YES _____ **NO** _____ **NAME:** _____

ADDRESS: _____ **PHONE:** _____

Armed Forces: Did you or your Spouse ever serve in the Armed Forces?

You: Yes:___ No:___ Spouse: Yes ___ No ___ Country: _____

Dates:_____ Serial #_____

OTHER CONTACTS: ADDRESS (ZIP CODE) RELATIONSHIP TELEPHONE

2) _____

3) _____

FINANCIAL DATA/ASSETS & DEBETS

MEDICARE NUMBER PART A PART B EFFECTIVE DATE
YES NO YES NO

MEDICAID NUMBER COUNTY EXPIRATION DATE:

BLUE CROSS # OTHER INSURANCE & #

SAVINGS & CHECKING ACCOUNTS: / BANK ADDRESS / ACCOUNT NUMBER AND AMOUNTS

STOCKS AND BONDS: VALUES:

SOCIAL SECURITY # AMOUNT:

EMPLOYER PENSION NAME: PENSION #

ADDRESS: AMOUNT:

UNION NAME LOCAL # AMOUNT:

ADDRESS:

V.A.PENSION / OTHER PENSIONS NAME AMOUNTS

ADDRESS:

PUBLIC ASSISTANCE #: NAME OF SOCIAL SERVICE CENTER

REAL ESTATE: LOCATION AND TYPE VALUE++:
YES NO

AMOUNTS OF INCOME OR FENTAL: AMOUNT OF MORTGAGE:

SAFE DEPOSIT LOCATION: _____ BOX _____

ADDRESS: _____

LIFE INSURANCE COMPANY ADDRESS POLICY # AMOUNT: _____

IF PRIVATE PAYING: BILL WILL BE SENT TO:

Name: _____ Relationship: _____

Address: _____ Phone# _____

NAME OF CEMETERY _____ ADDRESS: _____

PLOT # / OR CRYPT SECTION: RANGE: _____

WHO HOLDS DEED? _____

FUNERAL DIRECTOR & ADDRESS: _____

CHURCH OR SYNAGOGUE & ADDRESS: _____

WILL EXECUTED EXECUTORS NAME ADDRESS: _____

YES NO _____

ATTORNEY AT LAW PHONE #: _____

ADDRESS: _____

PHYSICIAN'S NAME PHONE # _____

ADDRESS: _____

DENTIST'S NAME: PHONE # _____

ADDRESS: _____

IF NOT AT HOME, STATE PRESENT LOCATION SINCE _____

ADDRESS: _____

MAJOR HOSPITALIZATIONS:

NAME OF HOSPITALS DATE OF ADMISSION LENGTH OF STAY REASON _____

PRESENT CONDITION OF APPLICANT:

	YES	NO		YES	NO
INCONTINENT	_____	_____	WANDERS	_____	_____
CONFUSED	_____	_____	FORGETFUL	_____	_____
USES EYEGLASSES	_____	_____	DENTURES	_____	_____
ABLE TO FEED SELF	_____	_____	HEARINGAID	_____	_____
ABLE TO DRESS SELF	_____	_____	SPECIAL DIET	_____	_____
PSYCHIATRIC HISTORY	_____	_____			
OTHER:					

PRIMARY LANGUAGE SPOKEN

ACCORDING TO MY KNOWLEDGE, THE FOREGOING INFORMATION IS COMPLETE, ACCURATE AND TRUE IN ALL ASPECTS.

SIGNATURE OF APPLICANT OR RESPONSIBLE PARTY

WITNESS

DATE

PLEASE RETURN COMPLETED APPLICATION TO THE SOCIAL SERVICE DEPARTMENT.

If at any time, for any reason (placement in another home, change in plans, death, etc.) you should no longer wish to keep this application on file, it would be appreciated if you would let the Social Service Department know, by letter or telephone, so that our files may be kept as current as possible.

FEDERAL AND STATE LAW PROHIBITS THIS FACILITY FROM DENYING ADMISSION TO ANYONE BECAUSE OF RACE, CREED, COLOR OR NATIONAL ORIGIN.

PRE-ADMISSION PHYSICAL

NAME: _____ **DATE OF BIRTH** _____

ADDRESS: _____

MEDICAL HISTORY _____

SOCIAL HISTORY: _____

PRESENT

MEDS: _____

ALLERGIES: _____

PHYSICAL EXAMINATION: GENERAL APPEARANCE / MENTAL STATUS: _____

HEENT: _____ **NECK:** _____ **CHEST:** _____

WT: _____ **TEMP:** _____ **BP** _____ **RR** _____ **PULSE** _____

HEART: _____ **LUNGS:** _____

ABDOMEN/PELVIC _____

RECTAL: _____

EXTREMITIES (INCLUDING CONTRACTURES): _____

NEURO: _____

CHEST X-RAY: _____

EKG: _____

LAB: _____

OTHER: _____

DATE OF LAST PNEUMOVAX: _____ **Last Mantoux/PPD** _____ **Negative date:** _____

Positive Date: _____ **T.B. treatment if any** _____

Flu Vaccine: Yes: _____ **Date:** _____ **No:** _____

DIAGNOSIS: _____

PHYSICIAN'S SIGNATURE

PHYSICIAN'S NAME & ADDRESS

DATE: _____

PHONE NUMBER _____

**PROVIDENCE REST NURSING HOME
3304 WATERBURY AVENUE
BRONX, NEW YORK 10465**

**OPHTHALMOLOGY DEPARTMENT
REPORT FOR GLAUCOMA**

DATE: _____

NAME OF PATIENT _____ **AGE:** _____ **SEX** _____

1. a) Vision with glasses **RIGHT** _____ **LEFT** _____

 b) Vision without glasses **RIGHT** _____ **LEFT** _____

2. a) Has this patient any history of glaucoma? Yes _____ No _____

 b) If YES, in what year did the condition appear? _____

 c) Is patient at present under treatment for glaucoma? Yes _____ No _____

 d) If yes, please specify the mode of treatment, including all medications the patient is now receiving.

3. a) Has the patient any history of ocular disease or disability other than glaucoma?
 YES _____ **NO** _____

 b) If yes, please indicate the nature of the disease or disability and the mode of treatment. _____

 c) Specify the degree of incapacity and effect on functioning. _____

Functional Limitations: _____

Special precautions to be observed: _____

Physician's Name

Signature