ST. CLARE NEWPORT
309 Spring Street, Newport, Rhode Island 02840
401.849.3204 | www.stclarenewport.com

APPLICATION FOR ADMISSION

Please complete & return application to St. Clare-Newport to be considered for admission. *Criteria for admission are the same for all persons without regard to race, gender, national origin, age, physical or mental impairments or financial resources.*

APPLICATION FOR ADMISSION FOR:

Name:_____
Last, First Middle

Present Address:_____
Number & Street City Zip

Phone: ( ) _____ - _____ Email: _____

Permanent Address:_____
Number & Street City Zip

Phone: ( ) _____ - _____ Sex: Female _____ Male_____

Date of Birth:____/____/_____ Age:_____ Place of Birth: _____
City, State

Marital Status: Married _____ Divorced _____ Widowed _____ Single_____ Separated_____

Religion: _____ Place of Worship: _____

Lifetime Occupation:_____ Education: _____

Primary Language:_____ US Citizen?: Yes_____ No _____

Burial Plan?: Yes____ No____ Funeral Director:_____

St. Clare-Newport was recommended by:_____

CONTACT PERSON for applicant/application: *(if other than applicant and/or spouse)*

Name: _____ Phone: ( ) _____-_____

Address:_____ Email: _____

READINESS FOR PLACEMENT

Please circle yes or no - the applicant is:

A.	In immediate need for placement	Yes	No
B.	Is presently in the hospital	Yes	No
C.	Is living in the community	Yes	No
D.	Is planning ahead for possible future needs	Yes	No

E. Please provide a brief description of the applicant's medical needs and the reason for placement:

_____

_____

_____

_____

RELATIVES OR SIGNIFICANT OTHERS

Person(s) to be notified in an Emergency:

FIRST

Name:_____ Email: _____

Address:_____Relationship_____

Number & Street City Zip

Telephone: (H)_____(W)_____(C)_____ - - *Please circle best number to contact*

SECOND

Name:_____ Email: _____

Address:_____Relationship_____

Number & Street City Zip

Telephone: (H)_____(W)_____(C)_____ - - *Please circle best number to contact*

PHYSICIANS/HOSPITALIZATIONS

Primary Care:_____ Address:_____ Phone:_____

Date of last visit:____/____/_____ Will physician continue to follow at St. Clare-Newport? Yes___ No____

Physicians/Specialists consulted in past 2 years: *(Please continue list on back of sheet as needed)*

Name:_____ Address:_____ Phone:_____

Specialty: _____

Name:_____ Address:_____ Phone:_____

Specialty: _____

Hospitals utilized during the past 2 years: *(Please continue list on back of sheet as needed)*

Name:_____ Address:_____ Dates:_____

Reason:_____

Name:_____ Address:_____ Dates:_____

Reason:_____

Nursing Home or Rehabilitation Facility utilized with the LAST year: *(Please continue list on back of sheet as needed)*

Name:_____ Address:_____ Dates:_____

Reason:_____

FINANCIAL/BILLING INFORMATION

HEALTH INSURANCE: *Kindly provide copies of all medical/insurance coverage cards*

Social Security Number: _____-_____-_____

Federal Medicare #:_____

State Medicaid #:_____ Effective Date:_____

Social Worker: _____

Telephone #: _____ District Office:_____

Other Insurance: _____ #:_____

Veteran's Claim #:_____

By definition, a patient in Rhode Island is considered private paying until their individual assets are spent down to the R. I. Medicaid Eligibility Limit of $4,000.00. Anyone who has less than $4,000.00 upon application would be eligible to apply for R.I. Medicaid Assistance through the R. I. Department of Human Services prior to admission. In order for St. Clare-Newport to project the Private Pay and Medicaid Census, we request your assistance in completing the following questions:

Please circle one - Based on the above criteria, the applicant would be:

Private Pay ***or*** Medicaid Eligible

A. If paying privately, at the daily rate of $_____, the applicant predicts that: They would remain private paying for approximately (indicate length of time, i.e. months/years):_____

B. If there is a need for Medicaid Long Term Care Assistance, the applicant has:

_____ Already applied with a decision of eligibility

_____ Already applied with decision pending

_____ Not begun application yet

_____ A need to obtain further information regarding how to begin the decision-making process of Medicaid application.

A. The applicant has Long Term Care Insurance: Yes _____ No _____

B. If yes, with whom is the applicant insured?: _____
Name of Insurance Company

B. If yes, please summarize the applicant's coverage by the Long Term Care Insurance Policy: Please indicate the payment amount and length of duration of coverage: _____

_____

DOES APPLICANT HAVE: *(Please circle yes or no)*

LEGAL GUARDIAN Yes No

Name:_____ Email:_____

Address:_____
Number & Street City Zip

Phone: (H)_____(W)_____(C)_____ Relationship:_____

POWER OF ATTORNEY Yes No

Name:_____ Email:_____

Address:_____
Number & Street City Zip

Phone: (H)_____(W)_____(C)_____ Relationship:_____

TRUSTEE Yes No

Name:_____ Email:_____

Address:_____
Number & Street City Zip

Phone: (H)_____(W)_____(C)_____ Relationship:_____

NOTE: If applicable, documentation of Legal Guardian, Power of Attorney, and/or Trustee will be needed at the time of admission.

FINANCIAL RESPONSIBLE PARTY: *Individual responsible for payment of account*

FIRST

Name:_____ Email:_____

Address:_____

Number & Street City Zip

Phone: (H)_____(W)_____(C)_____ Relationship:_____

SECOND

Name:_____ Email:_____

Address:_____

Number & Street City Zip

Phone: (H)_____(W)_____(C)_____ Relationship:_____

PLEASE INDICATE PERSON COMPLETING FORM:

Circle one - - Applicant or Designee

Form Completed by: _____ Date: _____

SCN Staff receiving application: _____ Date: _____