Date Rec'd ___________

Saint Antoine Community

THE ULTIMATE IN ASSISTED LIVING
AND EXCELLENCE IN NURSING AND REHABILITATIVE CARE

☐ **The Villa at Saint Antoine**
Traditional Assisted Living
400 Mendon Road
North Smithfield RI 02896

☐ **Primrose Lane**
Assisted Living, Memory Care
10 Rhodes Avenue
North Smithfield, RI 02896

☐ **Saint Antoine Residence**
Long term Care / Rehab
10 Rhodes Avenue
North Smithfield RI 02896

Applicant Name: ______________________________ Gender: ☐ Male ☐ Female

Address: ______________________________ City: ____________ State: _____ Zip: ______

Phone: ___________ Email Address: ______________________________ Marital Status: _________

Date of Birth: __________ Place of Birth: ____________ Social Security Number: ______________

Medicare Number: ________________ Secondary Insurance Number: ______________________

Do you have Long Term Care Insurance? ______ Company: ______________________________

Burial Plan: ☐ Yes ☐ No Funeral Director: ______________ Phone: ______________________

Religion: ________________ Place of Worship: ____________________

Primary Language: ______________ Former Occupation: ______________________

NAME OF PRIMARY CONTACT PERSON: (Please indicate if Power of Attorney for Finance, Healthcare, or Guardian if applicable)

Name: ______________________________ Relationship: ____________________

Address: ______________________________ City: ____________ State: _____ Zip: ______

Home Phone: ________________ Cell: __________________ Work: ________________

Email Address: ______________________ Legal Designation, if any: ____________________

EMERGENCY CONTACT: (If different from Contact Person listed)

Name: ______________________________ Relationship: ____________________

Address: ______________________________ City: ____________ State: _____ Zip: ______

Home Phone: ________________ Cell: __________________ Work: ________________

Email Address: ______________________ Legal Designation, if any: ____________________

MEDICAL INFORMATION

How would you describe your present state of health? ______________________________

____

Primary Physician: ____________________ Phone: ______________ Fax: __________

Address: __________________________ City: ____________ State: ______ Zip: ______

Hospital Preference: ____

List Medical Specialist: (if applicable)

Name: ________________ Specialty: ________________ Phone #: ________________

Name: ________________ Specialty: ________________ Phone #: ________________

Name: ________________ Specialty: ________________ Phone #: ________________

List Medications you are presently taking or attach a list: ______________________________

____

List any Behaviors and health conditions that might require extra supervision such as wandering, elopement risk and sundowning, insulin, medications, blood pressure, skin condition:

____

____

Are you on a special diet? ☐ Yes ☐ No If yes, explain ______________________________

Is incontinence a problem? ☐ Yes ☐ No If yes, explain ______________________________

I need assistance with: ☐ Medication Administration ☐ Bathing ☐ Dressing

☐ Escort Service ☐ Housekeeping & Laundry ☐ Incontinence Management

Other-explain ____

Mobility: ☐ Independent ☐ Cane ☐ Walker ☐ Self-Propelled Wheelchair ☐ Wheelchair

FINANCIAL INFORMATION

By definition, a patient in Rhode Island is considered private paying until their individual assets are spent down to the RI Medicaid Eligibility Limit of $4000.00. Anyone who has less than $4000.00, upon application, would be eligible to apply for RI Medicaid Assistance through the RI Department of Human Services, prior to admission. In order for our home to project the Private Pay and Medicaid Census, we request your assistance in completing the following page: Based on the above criteria, the applicant would be: (Please circle one)

Private Pay or Medicaid Eligible

INCOME	MONTHLY AMOUNT
Social Security	$
SSI	$
Pension/Annuities	$
Trust	$
Other Monthly Income	$
Total	$
LIABILITIES	
Mortgage	$
Loans	$
Other	$
Total	$

ASSETS	DESCRIPTION	AS OF (DATE)	VALUE
Real Estate Owned			$
Savings Account			$
Checking Account			$
Retirement Account			$
Stocks and Bonds			$
Other Assets			$
		TOTAL ASSSETS	$

Does the death of one applicant alter the assets of the other applicant? ☐ Yes ☐ No

Explain ____

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

Private Pay or Medicaid Eligible

FINANCIAL RESPONSIBILITY

Does someone other than you administer your finances? ☐ Yes ☐ No If Yes, please fill out box below

Billing contact, if not applicant:
Name: ______________________________
Address: ____________________ City: ____________
State: _______ Zip: ______
Home Phone: ____________ Cell: ____________
Relationship: ____________

I understand and agree that the foregoing application is not a contract or reservation for residence. Nothing contained herein is binding on either party until a Admission/Residency Agreement has been signed by the parties hereto. All information contained in this application, is true and correct to the best of my knowledge.

____________________________ ________________
Signature of Applicant/Responsible Party Date

PHYSICIAN'S MEDICAL QUESTIONNAIRE

*******TIME SENSITIVE DOCUMENT*******

Patient Name: ______________________________

Date of Birth: ______________________________

Physician's Name ______________________________

Physician's Address: ______________________________

____

Physician's Telephone: ______________________________

Physician's Fax: ______________________________

I hereby authorize the above named physician to release medical information requested by Saint Antoine Community.
This information will be kept confidential and it will be used only for the purpose of determining the most appropriate level of service to meet the above named patient.

______________________________ ______________________________

Patient's Signature Date

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