

**Daughters of Sarah Nursing Center
Scheduled Short Term Care Program**

APPLICATION

Applicant's Name _____

Applicant's address _____

Telephone Number _____

Date of Birth _____ Marital Status _____

Social Security Number _____ Medicare Number _____

Medicaid Number _____ County _____

Person/Agency Responsible for payment _____

Primary Care Physician's Name _____

Address _____

Telephone Number _____

Other Physician's

Name _____ Specialty _____

Address _____ Phone # _____

Name _____ Specialty _____

Address _____ Phone # _____

In Case of Emergency, Notify _____

Address _____ Phone # _____

Reason for needing scheduled Short term Care stay _____

_____ Tentative date of stay _____

Has applicant stayed with us before ? No Yes (when) _____

**** NOTE:** If an acute emergency arises, Daughters of Sarah will transfer the resident to St. Peter's Hospital unless otherwise specified by your physician.

Signature _____

Date _____

Federal and State law prohibits the SSTC program from denying admission to anyone because of Race, Creed, Color, Religion, National Origin, Sexual Preference, Marital Status, Sex, Handicap, Sponsorship or the Presence or Absence of Advance Directive.