Crouse Community Center
101 South Street
Morrisville, NY 13408

Admission Date: ____________
Admitted From: ____________
Admission Time: ____________
Room Number: ____________

APPLICATION FOR ADMISSION

New York State and Federal laws prohibit discrimination in any form on the basis of race, creed, color, national origin, sex, handicap, or source of payment.

Name: ____________ Woman's Maiden Name: ____________
Address: ____________ Home Phone #: ____________
Date of Birth: ____________ ☐ F ☐ M Age: ____________ Race: ____________ Birthplace: ____________

Marital Status: ____________ Name of Spouse: ____________
Father's Name: ____________ Mother's Name: ____________
Applicant's Former Occupation: ____________ Education: ____________

Social Security #: ____________ Medicare #: ____________
Medicaid #: ____________ County: ____________
Prescription Plan: ____________
Other Health Insurance: ____________
Subscriber: ____________ Policy #: ____________ Group #: ____________
Is Applicant a Veteran? ____________ Is Spouse a Veteran? ____________ Veteran Claim #: ____________

Religious Preference: ____________ Funeral Home: ____________
Funeral Home Address: ____________ Telephone #: ____________
Organ Donation: ____________

PERSONS TO BE NOTIFIED IN AN EMERGENCY

☐ HCP ☐ POA ☐ Personal Caregiver Visitor ☐ Compassionate Caregiver Visitor
1. Primary Contact Person: ____________ Relationship: ____________
Address: ____________ Home Phone #: ____________
Work Phone #: ____________
E-Mail: ____________ Cell Phone #: ____________
Can Receive Text: ☐ Yes ☐ No

☐ HCP ☐ POA ☐ Personal Caregiver Visitor ☐ Compassionate Caregiver Visitor
2. Secondary Contact Person: ____________ Relationship: ____________
Address: ____________ Home Phone #: ____________
Work Phone #: ____________
E-Mail: ____________ Cell Phone #: ____________
Can Receive Text: ☐ Yes ☐ No

☐ HCP ☐ POA ☐ Personal Caregiver Visitor ☐ Compassionate Caregiver Visitor
3. Contact Person: ____________ Relationship: ____________
Address: ____________ Home Phone #: ____________
Work Phone #: ____________
E-Mail: ____________ Cell Phone #: ____________
Can Receive Text: ☐ Yes ☐ No

☐ HCP ☐ POA ☐ Personal Caregiver Visitor ☐ Compassionate Caregiver Visitor
4. Contact Person: ____________ Relationship: ____________
Address: ____________ Home Phone #: ____________
Work Phone #: ____________
E-Mail: ____________ Cell Phone #: ____________
Can Receive Text: ☐ Yes ☐ No

{Continued on Reverse Side}

Financial Information: Please list total amount applicant receives each month from Social Security, Pension, Salary, VA benefits, etc.: ____________________

Please check if you own: _____ Home _____ Homes _____ Properties

Approximate Financial Assets (not including home or vehicle)

_____ 0 - 14,999 _____ 15,000 - 49,999 _____ 50,000 - 84,999

_____ 85,000 - 99,999 _____ 100,000 - 199,999 _____ 200,000 +

Name of Financially Responsible Party: ____________________

Name of Power of Attorney: ____________________

Name of Health Care Proxy: ____________________

Name of Attending Physician: ____________________

Name of Primary Physician: ____________________

Date Application Completed: __________ Signature: ____________________

CCC/6-21/sdj