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 #:** ____________

Cemetery Lot: ____________

PERSONS TO BE NOTIFIED IN AN EMERGENCY

☐ **HCP** ☐ **POA**

1. Primary Contact Person: ____________ **Relationship:** ____________
Address: ____________ **Home Phone #:** ____________
____________ **Work Phone #:** ____________
Cell Phone #: ____________

☐ **HCP** ☐ **POA**

2. Secondary Contact Person: ____________ **Relationship:** ____________
Address: ____________ **Home Phone #:** ____________
____________ **Work Phone #:** ____________
Cell Phone #: ____________

☐ **HCP** ☐ **POA**

3. Contact Person: ____________ **Relationship:** ____________
Address: ____________ **Home Phone #:** ____________
____________ **Work Phone #:** ____________
Cell Phone #: ____________

☐ **HCP** ☐ **POA**

4. Contact Person: ____________ **Relationship:** ____________
Address: ____________ **Home Phone #:** ____________
____________ **Work Phone #:** ____________
Cell Phone #: ____________

{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/6-14/sdj