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
1. Primary Contact Person: _____ **Relationship:** _____
Address: _____ **Home Phone #:** _____
Work Phone #: _____
E-Mail: _____ **Cell Phone #:** _____
Can Receive Text: □ Yes □ No

□ HCP □ POA
2. Secondary Contact Person: _____ **Relationship:** _____
Address: _____ **Home Phone #:** _____
Work Phone #: _____
E-Mail: _____ **Cell Phone #:** _____
Can Receive Text: □ Yes □ No

□ HCP □ POA
3. Contact Person: _____ **Relationship:** _____
Address: _____ **Home Phone #:** _____
Work Phone #: _____
E-Mail: _____ **Cell Phone #:** _____
Can Receive Text: □ Yes □ No

□ HCP □ POA
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/1-17/sdj