

14. Name and address of Mortician _____

15. Does applicant have a gaurdian? Yes _____ No _____

If yes, give Name and Address of Guardian _____

16. If applicant has delegated another person with Power of Attorney, please list their name, address and telephone number:

17. List the name, address, telephone number and relationship of persons to be called in emergency.

18. Condition of applicant ----- Check all that apply

1.Ambulatory _____ Cane _____ Walker _____ Wheelchair _____

2.Colostomy Yes _____ No _____

3.Diabetic Yes _____ No _____

Insulin Dependent Yes _____ Name of Insulin _____ # of units taken per day _____

4.Incontinent of urine Yes _____ No _____ Wears Protective Pad _____

5.Incontient of bowel Yes _____ No _____ Wears Protective Pad _____

6.List medications _____

7.List any hospitalizations and surgeries the applicant may have had:

8.Does the applicant have any medication or food allergies: Yes _____ No _____

If yes please list allergies and reactions. _____

9.Does applicant have any infections at the present time? Yes _____ No _____

19. Does the applicant need financial assistance? Yes _____ No _____
Information on financial assistance is in the packet.

20. Expected stay at facility: Short term _____ Long Term _____