## MORNINGSIDE CENTER NURSING HOME & APARTMENTS APPLICATION FOR ADMISSION

For Facility Use:			
Date/Time Received			
Contact Person			
Nursing Home	Date	_	
Apartments			
Apartments Please Check One or Both if needed			
1. Name			
2. Present Address			
2. Present AddressStreet	City		
County State	Zip Code		
3. Birthdate			
4. Marital Status			
5. Have you lived and paid taxes in Livingston	n County?		
6. Former Occupation		<u>.</u>	
7. Social Security Number			
8. Medicare Number			
9. Religion			
10. Name and address of Pastor		_	
11. Name and address of Doctor			
12. Name and address of Dentist		_	
13. Name and address of Optomitrist		_	

14. Name and address of Mortician	
15.	Does applicant have a gaurdian? Yes No
lf ye	es, give Name and Address of Guardian
	If applicant has delegated another person with Power of Attorney, please list their name, lress and telephone number:
	List the name, address, telephone number and relationship of persons to be called in ergency.
18.	Condition of applicant Check all that apply  1.Ambulatory Cane Walker Wheelchair  2 Colostomy Yes No
	1.Ambulatory Cane Walker Wheelchair  2.Colostomy Yes No 3.Diabetic Yes No Insulin Dependent Yes Name of Insulin # of units taken per
	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