

# ADMISSION APPLICATION

FULL NAME \_\_\_\_\_

ADDRESS \_\_\_\_\_

SOCIAL SECURITY NO. \_\_\_\_\_ PHONE NO. \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ PLACE OF BIRTH \_\_\_\_\_

MARITAL STATUS: M \_\_\_\_\_ S \_\_\_\_\_ SEP. \_\_\_\_\_ D \_\_\_\_\_ W \_\_\_\_\_

NAME OF SPOUSE \_\_\_\_\_

DATE OF DEATH (IF DECEASED) \_\_\_\_\_

YOUR CHILDREN:

NAME	ADDRESS	PHONE

**CLOSE RELATIVES:**

NAME	HOW RELATED	ADDRESS	PHONE

**IN CASE OF EMERGENCY NOTIFY:**

NAME	RELATIONSHIP	ADDRESS	PHONE

EDUCATIONAL BACKGROUND: \_\_\_\_\_

PROFESSIONAL/CAREER: \_\_\_\_\_

MILITARY EXPERIENCE: \_\_\_\_\_

CHURCH AFFILIATION: \_\_\_\_\_

NAME, ADDRESS, PHONE NO. OF MINISTER: \_\_\_\_\_

(cont. on page 2)

**HEALTH RECORD:**

COMPANY AND POLICYNUMBER OF HEALTH INSURANCE

\_\_\_\_\_

COMPANY NAME AND POLICY NUMBER OF LONG-TERM CARE INSURANCE

\_\_\_\_\_

MEDICARE NUMBER \_\_\_\_\_

DATES AND NATURE OF ILLNESSES/OPERATIONS

\_\_\_\_\_

\_\_\_\_\_

PHYSICIAN’S NAME, ADDRESS, PHONE: \_\_\_\_\_

DENTIST’S NAME, ADDRESS, PHONE: \_\_\_\_\_

OPTOMETRIST’S NAME, ADDRESS, PHONE: \_\_\_\_\_

\_\_\_\_\_

**FINANCIAL RECORD:**

SOCIAL SECURITY .....	\$	_____
RAILROAD RETIREMENT .....	\$	_____
VETERAN’S PENSION.....	\$	_____
IPERS.....	\$	_____
ANNUITIES.....	\$	_____
OTHER INCOME .....	\$	_____
VALUE OF HOME/FARM.....	\$	_____
SAVINGS AND/OR INVESTMENTS .....	\$	_____
TRUST FUND .....	\$	_____
LIABILITIES .....	\$	_____

**BURIAL INFORMATION:**

DO YOU HAVE A BURIAL AGREEMENT? \_\_\_\_\_

NAME OF PERSON RESPONSIBLE FOR FUNERAL ARRANGEMENTS:

\_\_\_\_\_

NAME AND ADDRESS OF FUNERAL DIRECTOR TO BE CALLED:

\_\_\_\_\_

\_\_\_\_\_  
APPLICANT’S SIGNATURE

\_\_\_\_\_  
DATE