## Tuscola County Medical Care Community

Your Care Partner in Skilled Nursing and Rehabilitation Therapy

1285 CLEAVER ROAD ◆ CARO, MICHIGAN 48723 PHONE (989) 673-4117 ◆ FAX (989) 673-6665

## **ADMISSION APPLICATION**

Name:	Phone:	Cell:
Home Address:	City:	State: Zip:
Home County:	Place of Birt	th:
SEX: Female / Male Age:	DOB: MDY	Social Security #:
Civil Status:	Occupation:	Religion:
		No Primary Language:
rimary Care Physician:		Phone:
		Phone:
NSURANCE INFORMATION	N: ** MUST PROVIDE <u>ALL</u> INSUR	ANCE CARDS UPON ADMISSION**
		Medical Ins(B):
		Medicaid No.:
		VA Status and No.:
14c C1 086 1 10		
Other Insurance's:Ooes applicant have a DPOA, I	OMPOA, or Guardian? Yes No	**Must provide copies upon admission
Other Insurance's:	OMPOA, or Guardian? Yes No	**Must provide copies upon admission
Other Insurance's: Does applicant have a DPOA, I Dame of person responsible for 1) Name:	OMPOA, or Guardian? Yes No  patients payment to the Medical Car Relationship:	**Must provide copies upon admission re Facility:
Other Insurance's: Ooes applicant have a DPOA, I Name of person responsible for 1) Name: Address:	OMPOA, or Guardian? Yes No r patients payment to the Medical Car Relationship: City:	**Must provide copies upon admission re Facility: Phone:
Other Insurance's:  Does applicant have a DPOA, I  Name of person responsible for  1) Name:  Address:  Email Address:	OMPOA, or Guardian? Yes No  patients payment to the Medical Car Relationship: City:	**Must provide copies upon admission re Facility: Phone: State: Zip:
Other Insurance's: Does applicant have a DPOA, I Name of person responsible for 1) Name: Address: Email Address: Person(s) to contact in case of e	OMPOA, or Guardian? Yes No r patients payment to the Medical Car Relationship: City:	**Must provide copies upon admission re Facility: Phone: State: Zip:
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Other Insurance's:	OMPOA, or Guardian? Yes No repatients payment to the Medical Car Relationship: City: Relationship: City: City: Relationship: City: Relationship: Relationship:	**Must provide copies upon admission re Facility: Phone:State:Zip:Cell:Phone:State:Zip:Cell:Phone:State:Zip:Cell:State:Zip:Cell:State:Zip:Cell:State:Zip:

Date:\_\_

Signed:\_