WILLING HELPERS' HOME FOR WOMEN, INC.
226 WEST MADISON AVENUE
JOHNSTOWN, NEW YORK 12095

MEDICAL INFORMATION

1. NAME OF APPLICANT_______________________________________
2. PRIMARY PHYSICIAN_______________________________________
3. PHYSICIAN'S ADDRESS_________________________PHONE_______
4. HOSPITAL OF CHOICE_______________________________________
5. SOCIAL SECURITY #____
6. MEDICARE#____________________MEDICAID #__________________
7. OTHER HEALTH INSURANCE__________________________________
8. POLICY #______________________GROUP #______________________
9. DO YOU SMOKE?______ DO YOU CONSUME ALCOHOL?__________

<u>OTHER PHYSCIANS:</u>

PHYSICAN___________________TYPE OF PHYSICIAN_____________

ADDRESS____________________________PHONE #________________

PHYSICAN___________________TYPE OF PHYSICIAN_____________

ADDRESS____________________________PHONE #________________

I USE THE FOLLOWING ADAPTIVE EQUIPMENT: (PLEASE CIRCLE)

GLASSES, CONTACT LENSES, DENTURES, HEARING AIDS,
WALKER, CANE.

PLEASE LIST NAMES ADDRESSES AND TELEPHONE NUMBERS OF NEAREST RELATIVES, INCLUDING SIBLINGS:

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I understand that any misstatements or omissions in answering any of the foregoing questions will be sufficient grounds for rejection of my application.

I understand that a physical examination by a doctor approved by the Board of Managers of the home is required of each applicant. The fee for one examination will be paid by the Board. However, if the applicant decides not to accept the admission, she must assume the cost of the examination.

I understand that, if the Board accepts this application, there is an agreement and assignment to be signed by me before I enter the home as a resident.

SIGNATURE OF APPLICANT____________________________DATE________

SIGNATURE OF WITNESS______________________________DATE________