11 Bryant Drive, Sussex, NB E4E 2P3
www.kiwanisnursinghome.com

Phone (506) 432 – 3118
Fax No. (506) 432 – 3104
Email knhi@nb.aibn.com

APPLICATION

NAME ____

Address ____

____
Postal Code

Date of Birth _________________ Place of Birth _________________ Religion __________________________
Day/Month/Year Church __________________________
Medicare # ___________________________ Medicare Card Expiry Date ____________

PLEASE PROVIDE A COPY OF THE MEDICARE CARD WITH RETURNED APPLICATION

Blue Cross _____________ Other Coverage _____________ Name of Doctor ___________________________

S.I.N. # _____________________ Marital Status: Married _______ Single _______ Other __________________

Names(s) of Person(s) with Power of Attorney ____

PLEASE PROVIDE A COPY OF THE POWER OF ATTORNEY WITH RETURNED APPLICATION

CONTACT PERSONS:

1. Name ______________________________ Relationship ________________ Phone: Home ______________
Address: Work ______________
____
Postal Code
Email ____

2. Name ___________________________ Relationship _________________ Phone: Home ______________
Address: Work ______________
____
Postal Code
Email ____

NEXT OF KIN (Other than above):

1. Name ___________________________ Relationship _________________ Phone: Home ______________
Address: Work ______________
____
Postal Code
Email ____

2. Name ___________________________ Relationship _________________ Phone: Home ______________
Address: Work ______________
____
Postal Code
Email ____

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FINANCIAL:

Old Age Pension Monthly Amount ______________________________
Other Pension Monthly Amount ______________________________
Other Income Monthly Amount ______________________________

Will Financial Assistance be necessary? ____ Have arrangements been made? _______

Is applicant eligible for financial assistance from the Dept. of Veterans' Affairs? _______If yes, please provide DVA Client ("K") Number ___________________

PLANS FOR BURIAL:

Name and Address of Funeral Home ____

____

Cremation: Yes ☐ No ☐ Unknown ☐

SPONSOR (Person with Power of Attorney):

Name ____ Phone: Home ______________
Work __________ _____

Address ____
Postal Code

AGREEMENT OF REMOVAL

I hereby agree to remove the above-named person from the facilities of the Kiwanis Nursing Home Inc. if at any time he/she should become troublesome or beyond the care of the home, in the discretion of the Board of Directors.

____
Signature of Sponsor

NOTICE OF DISCHARGE: (office use only)

Left or Discharged____
Signature of Responsible Party

Reason: ______________________________ Condition ___________________________________

Forwarding Address: ____

____
Signature of Administrator