



COUNTY OF MORRIS

DEPARTMENT OF SENIOR, DISABILITY AND VETERAN SERVICES

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Divisions

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MORRIS VIEW NURSING HOME - APPLICATION FOR ADMISSION

NAME: _____

ADDRESS: _____

TOWN: _____ PHONE: _____

BIRTHDATE: _____ MALE: _____ FEMALE: _____

1) Are you a Morris County resident? ____ Yes ____ No

If so, how long have you lived in Morris County? ____ Years ____ Months

If not, does a family member reside in Morris County? ____ Yes ____ No

Name: _____ Relation: _____

Address: _____ Town: _____

2) I have applied for Medicaid. ____ Yes ____ Date ____ No

3) In what county did you apply? _____

4) I have been found eligible for Medicaid. ____ Yes ____ Date ____ No

5) I have ____ have not ____ transferred real estate or other resources (example: bank accounts, cash, stocks, bonds, etc.) within the last three years.

6) The resident is currently: At Home: _____

In a hospital: _____
(Name of Hospital)

In another facility: _____
(Name of Facility)

Signature of Applicant: _____

or

Signature of Representative/Responsible Party: _____

Relationship: _____ Date: _____

Contact Address: _____ Town: _____

Phone #: _____ Bus.#: _____

PLEASE RETURN TO THE ADDRESS BELOW:

Morris View Nursing Home
P.O. Box 437
Morris Plains, New Jersey 07950
ATTN: Admissions
Fax#: (973) 631-5189