DATE: ________________________________

APPLICATION FOR RESIDENCY

I. GENERAL INFORMATION

Applicant Name ____ Social Security # ____________________

Address ____

City ____ State _______ Zip Code ____________________

Telephone ___________________________ Birth Date ____/____/_____ Gender: ☐ Male ☐ Female

How long has applicant lived at this address? ___________ ☐ Months ☐ Years

Does the applicant have an Elderly & Persons with Disability Waiver? ☐ Yes ☐ No ☐ In Process

Current or former occupation ____

Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Other ____________________

Case Manager Name ____________________________________

Telephone _____________________________ Email Address ____________ __________________

In an emergency, who should we call?

Name _____________________________________ Relationship ___________________________________

Address ____Telephone ____________________

Advance Directives *(If yes, please provide a copy of the documents)*

Has applicant completed a living will or advanced directive? ☐ Yes ☐ No

Has applicant made a decision about DNR (do not resuscitate) orders? ☐ Yes ☐ No

II. CURRENT LIVING SITUATION

Do you currently own your own home or rent? ☐ Own ☐ Rent ☐ Other

What type of housing do you live in? ☐ Apt/House ☐ ALR/Senior Housing ☐ Nursing Home ☐ Other

Current monthly rental rate _________

If rental, Name of Landlord/Owner/Manager ________________________Telephone ____________________

Are there any problems or concerns which our staff should be aware of or any special support you might need in our community? ____

Do you require someone (friend, relative or other person) to live with you now? ☐ Yes ☐ No

If yes, who: __________________________ Reason for this need? ___________________________________

If not, do you require someone to visit you during the day? ☐ Yes ☐ No

If yes, reason for a visit? __________________________________ How long is a visit? __________________

III. MEDICATION INFORMATION AND INSURANCE

Primary Care Provider’s Name ____

Address ________________________________ Telephone ____________________

Hospital Affiliation ____

Secondary or Other Physician's Name ____________________________________

Address ________________________________ Telephone ____________________

How would you describe your present state of health? _____________________

How often do you see your doctor? ______________When was your last visit? ______________

Are you on any medications? ☐ Yes ☐ No (*If yes, attach a list of medications with condition being treated*)

Do you require assistance to administer the medication? ☐ Yes ☐ No

Are you on a special or restricted diet? ☐ Yes ☐ No If yes, describe ____________________

How much walking do you do? __________ Do you use a cane, walker or a wheelchair? ____________

Please list all of your medical insurance coverage's, including supplemental and long term care:

Medicaid ______________________ Policy No: ______________________

Medicare ______________________ Policy No: ______________________

______________________ Policy No: ______________________

IV. DAILY LIVING

Please use an "X" to indicate your level of ability in the following area:

	I can handle this myself	I need some assistance	Comments
Bathing			
Dressing			
Mouth or Skin Care			
Shaving or Grooming			
Toileting			
Escort/Mobility			
Medication Reminder			
Housekeeping/Laundry			

Is there any other information we should be aware of when reviewing your health and medical concerns?

____

I understand and agree this application is neither a contract, nor a reservation for residence. Nothing contained in this document is legally binding on either myself or the community to which I am applying for residency, until a Residency Agreement has been approved and signed by all parties involved.

______________________________________ ______________________

Signature of Applicant Date of Application

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Name of Person Assisting with Application