DATE: _____

ABRAMS ASSISTED LIVING

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

Does the applicant have Supplemental Security Income (SSI) or is it in process? ☐ Yes ☐ No ☐ In Process

Have you applied for SSI ☐ Yes ☐ No If so, what was the date of the application? _____

Have you applied for SSDI ☐ Yes ☐ No If so, what was the date of the application? _____

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

Has the applicant decided 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

Name of Person Assisting with Application