The Lodge At Old Trail
A Senior Living Community

Application for Residency

I. General Information

Resident Name: _____ Social Security Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

How long at this address? _____ years.

Telephone where resident can be reached: _____ Birth Date: _____

Birth Place: _____ Gender ☐ Male ☐ Female

Current or former occupation: _____

Marital Status : ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

In an emergency, who should we call?

Name _____

Address _____

Phone _____ Relationship: _____

II. Advance Directives and Power of Attorney

Have you completed a living will or advanced directives ☐ Yes ☐ No

Have you made a decision about DNR (do not resuscitate) orders? ☐ Yes ☐ No

If yes, what have you decided? _____

Do you have a VA. DNR order form completed and signed by your physician? ☐ Yes ☐ No

Power of Attorney for Health Care ☐ Yes ☐ No

If yes, who? _____ Relationship _____

Power of Attorney for Finances ☐ Yes ☐ No

If yes, who? _____ Relationship _____

(please provide with copies of all documents on advance directives, DNR and Power of Attorney)

III. Current Living Situation

What type of housing do you live in?

☐ In own home ☐ In a family member's home ☐ Nursing Home

☐ Regular assisted living ☐ Memory care assisted living ☐ Other

Do you own an automobile? ☐ Yes ☐ No Make and Year _____
Do you drive regularly? ☐ Yes ☐ No Do you intend to maintain a car? ☐ Yes ☐ No

Are there any problems or concerns 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 at the present time?
If so, 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? _____
Are you considering other housing alternatives? ☐ Yes ☐ No
If so, which ones? _____

IV. Medical and Insurance Information

Primary Physician's name: _____
Address _____
Telephone _____ Hospital Affiliation: _____

Secondary or Other Physician's name: _____
Address _____
Telephone _____ Hospital Affiliation: _____

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 at the present time? ☐ Yes ☐ No
If yes, please specify the medication and condition being treated: _____

_____

_____

Do you require assistance to administer the medications? ☐ Yes ☐ No
Do you prepare your own meals? ☐ Yes ☐ No If no, who does? _____
Are you on a special or restricted diet? ☐ Yes ☐ No If yes, please describe _____

How much walking do you do? _____ Do you have difficulty with stairs? ☐ Yes ☐ No

Do you use any assistance such as a cane, walker, or a wheelchair? _____

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

_____ Policy No. _____

_____ Policy No. _____

_____ Policy No. _____

(please provide us with copies of your insurance cards)

V. Daily Living

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

Task	"I can handle this myself"	"I need some assistance"	Comments
Bathing			
Dressing			
Mouth or Skin Care			
Shaving or Grooming			
Toileting			
Escort/Mobility			
Med Reminder			
Night Care			
Hskg/Clothing Mgt.			

Do you have hobbies, or areas of special interest to you? _____

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 _____