



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