



Confidential Application for Residency

Applicants Name: _____ Date: _____

Address: _____ Phone: _____

Date of Birth: _____ Marital Status: _____ Soc.Sec.#: _____

Please check yes or no and provide copies

Power of Attorney- Health Care/ Guardian over Person: Yes No

Power of Attorney- Finances/ Guardian over Estate: Yes No

Living Will: Yes No

Insurance please provide copies of Medicare and insurance cards

Medicare #: _____ Eff. Date: _____

Insurance: _____ Phone #: _____

Group #: _____ ID #: _____

Prescription Provider and #: _____

Emergency Contacts

Name: _____

Relationship: _____

Address: _____

(H) Phone: _____

(W) Phone: _____

(C) Phone: _____

Email: _____

Other Contact: _____

Billing

Name: _____

Relationship: _____

Address: _____

(H) Phone: _____

(W) Phone: _____

(C) Phone: _____

Email: _____

Health Information:

Hospital: _____ Dentist: _____

Primary Physician: _____ Phone: _____

Address: _____ Eye Doctor: _____

Phone: _____ Phone: _____

Specialist: _____

Allergies: _____

Funeral Home: _____

Address: _____

Phone: _____

Current Medical Conditions:

Please place a check mark to indicate applicant's level of ability in the following areas:

Task	Can handle alone	Needs some assistance	Total assistance
Grooming/Shaving			
Dressing			
Bathing			
Mouth/Skin Care			
Toileting			
Medication Management			
Walking/Mobility			
Rising from bed or chair			

Please indicate any issues with bladder or bowel incontinence, products used, or medications used for management: _____

Please indicate applicant's mental status, including diagnosis of Alzheimer's or dementia, confusion, anxiety, or depression: _____

Has the applicant had any issues with wander: Yes No

This applicant uses: Wheel Chair Walker Cane

If he or she uses a wheelchair; can applicant transfer unassisted: Yes No