Confidential Application for Residency

Applicants Name:____ Date:__________________

Address:____ Phone:______________________

Date of Birth:__________________ Marital Status:______________ Soc.Sec.#:____________________

Veteran:________________________ Branch: __________________ Rank: _______________________

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

Please provide Name of DPAO-Heath Care/Guardian: ____

Please Provide Name of DPOA-Finance/Guardian: ____

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:_____________________________

Billing

Name:_________________________________

Relationship:___________________________

Address:_______________________________

____

(H) Phone:_____________________________

(W) Phone:_____________________________

(C) Phone:_____________________________

Emergency Contacts Continued

Email:_________________________________ Email:_________________________________

Other Contact:____

Health Information:

Hospital:_______________________________________ Dentist:___________________________________

Primary Physician:_______________________________ Phone:____________________________________

Address:_______________________________________ Eye Doctor:_______________________________

Phone:____ Phone:____________________________________

Specialist:____

Allergies:____

Funeral Home:____

Address:____

Phone:____

Current Medical Conditions:

____

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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:____

____

____

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 ☐

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

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