CONFIDENTIAL APPLICATION FOR RESIDENCY

Are you completing this application on behalf of a resident? Yes ☐ No ☐

If yes, Name (Please Print): _____

Resident's Name: _____ Date: _____

Resident's Preferred Name: _____

Address: _____ Phone: _____

Date of Birth: _____ Marital Status: _____ SSN#: _____

Veteran: Yes ☐ No ☐ Branch: _____ Rank: _____

COVID-19 Vaccination: Please Provide Copy of Vaccination Card with Application

Type: _____ Date: _____ Type: _____Date: _____

Type: _____ Date: _____ Type: _____Date: _____

Guardianship and Durable Power of Attorney (DPOA): Please Provide Copies with Your Application

Name of Guardianship: _____

Name of DPOA for Health Care Decisions: _____

Name of DPOA for Financial Decisions: _____

Has DPOA Been Activated by a Physician: Yes ☐ No ☐ Unknown ☐

Does Resident have a Living Will: Yes ☐ No ☐ Unknown ☐

Insurance: Please Provide Copies of Medicare and Insurance Cards (front and back) with Application

Medicare #: _____ Eff. Date: _____

Insurance: _____ Phone #: _____

Group #: _____ ID #: _____

Prescription Provider and Telephone: _____

Emergency Contact

Name: _____

Relationship: _____

Address: _____

Cell Phone: _____

Work Phone Including Extensions: _____

Home Phone: _____

Email Address You Check Most Frequently: _____

Other Contact Information:

Other Contact Name: _____

Relationship to Emergency Contact: _____

Relationship to Resident: _____

Address: _____

Cell Phone: _____

Work Phone: _____

Home Phone: _____

Email: _____

Other Contact Name: _____

Relationship to Emergency Contact: _____

Relationship to Resident: _____

Address: _____

Cell Phone: _____

Work Phone: _____

Home Phone: _____

Email: _____

Health Information:

Primary Care Physician: _____

Physician Address: _____ Phone: _____

Dentist: _____

Dentist Address: _____ Phone: _____

Optometrist: _____ Phone: _____

Specialist: _____

Specialist Address: _____ Phone: _____

Does Resident Wear Eyeglasses? Yes ☐ No ☐

Does Resident Wear Hearing Aids? Yes ☐ No ☐

Does Resident Have False Teeth? Yes ☐ No ☐

Please List All Known Allergies:

_____

_____

_____

Please List All Medications Currently Taken at Home, Including Vitamins:

_____

_____

_____

_____

Please List Current Medical Conditions:

_____

_____

_____

Funeral Planning:

Funeral Home: _____

Address: _____

Phone: _____

Please Place a Checkmark to Indicate Resident's Level of Ability in the Following Areas:

Task	Can Handle Alone	Needs Some Assistance	Total Assistance	Number of Assistants
Grooming/Shaving				
Dressing				
Bathing				
Mouth/Skin Care				
Toileting				
Medication Management				
Walking/Mobility				
Rising from Bed or Chair				

Bladder or Bowel Incontinence: Please include Products Used or Medications Used for Management

_____

_____

_____

_____

_____

_____

Has Resident had any Issues with Wandering? Yes ☐ No ☐

Has Resident had any Issues with Aggression? Yes ☐ No ☐

Resident Uses:

☐ Wheelchair Motorized? Yes ☐ No ☐
Can Transfer In/Out of Wheelchair Unassisted? Yes ☐ No ☐

☐ Walker

☐ Cane

Mental Orientation: Please Describe Current Mental Status including day/month/year awareness, diagnosis of Alzheimer's or Dementia, Confusion, Anxiety, Depression or worries about transitioning to Assisted Living

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