

VILLAGECARE at 46 & TEN

APPLICATION FOR RESIDENCY

1. PERSONAL DATA

Name: _____ DOB: _____ Gender: Male ___ Female ___

Current Address: _____ City _____ State ___ Zip Code _____

Length of time at current residence: _____

Referred by: _____ Phone: _____

Status: Single ___ Married ___ Divorced ___ Separated ___ Widowed ___ Partner ___

Religion: _____ Practicing: Yes ___ No ___ Place of Worship: _____

Education: _____ Occupation: _____

U.S. Citizen: Yes ___ No ___ Primary Language: _____

Born in United States: Yes ___ No ___ If no, place of birth : _____

Primary Contact:

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Cell: _____ Work Phone: _____

Health Care Proxy: Yes ___ No ___ POA: Yes ___ No ___ Guardian: Yes ___ No ___

Agency: _____ Name of Contact at Agency: _____

2. FINANCIAL

Medicare: _____ Medicaid: _____ Medicaid Active: Yes ___ No ___

Supplemental Insurance Plan: _____ ID#: _____

Part D Plan Name: _____ ID #: _____

Social Security: _____ Amount: _____ / Supplemental Security Income: _____ Amount: _____

Pension: _____ Source: _____ Amount: _____ / Pension: _____ Source: _____ Amount: _____

Other Sources of Income (i.e. wages, distributions from an IRA):

Source: _____ Amount: _____ / Source: _____ Amount: _____

Checking Account(s) _____ / Savings Account(s) _____

Stocks, Bonds, CDs, Mutual Funds, Treasury Bills and Notes, IRA etc; _____

Burial Plan _____ Life Insurance: _____ Property: _____

3. HEALTH CARE

Medical Diagnoses: _____

Psychiatric/Cognitive

Diagnoses: _____

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Current Medication(s): _____

Primary Care Practitioner:

Name: _____ Address: _____ Phone: _____

Hospital of Choice:

Name: _____ Address: _____ Phone: _____

4. LEVEL OF ASSISTANCE

Ambulatory: Yes _____ No _____ w/ Cane: Yes _____ No _____ w/Walker: Yes _____ No _____

Wheelchair: Yes _____ No _____

Continence of Bladder: Yes _____ No _____

Continence of Bowel: Yes _____ No _____

Vision Impairment: Yes _____ No _____

Hearing Impairment: Yes _____ No _____

Speech Impairment: Yes _____ No _____

Requires Assistance: Bathing: Yes ___ No ___ Dressing: Yes ___ No ___ Medication: Yes ___ No ___

Grooming: Yes ___ No ___ Housekeeping: Yes ___ No ___ Laundry: Yes ___ No ___

STATEMENT OF APPLICANT'S NEED FOR AN ASSISTED LIVING ENVIRONMENT AT THIS TIME:

Applicant's Signature: _____ Date: ____/____/____

Application completed by: _____ Date: ____/____/____

Relationship to Applicant: _____