Application for Residency

HOLI Senior Living

Disclosure

This is an application for residency. I understand Management reserves the right to screen and evaluate applicant(s). Acceptance for Resident move-in will be determined after completion and review of the service and care plan and financial worksheet. Applicant hereby certifies that all of the information on this application is true and correct.

Date of Application: _____ Estimated Date of Move-In: _____

Apt. # (if available): _____ Waiting List? Y / N Willing to take alternate Apt. while on wait list? Y / N

Apartment Type Desired: _____ Private / Shared

Basic Information

Applicant Name: _____ Social Security #: _____

Drivers License #: _____

Resident prefers to be called: _____Referred by: _____

Date of Birth: _____ Sex: M / F Marital Status: Single / Married / Widowed / Other

Current Address: _____

City: _____ State: _____ Zip Code: _____

Email Address: _____ Phone: _____

If less than 2 years, please list previous address:

Previous Address: _____

City: _____ State: _____ Zip Code: _____

Wellness Information

Hair Color: _____ Eye Color: _____ Hospital of Choice: _____

Identifying Marks: _____

Do you have: Power of Attorney? Y / N Living Will or Advance Directives? Y / N (please provide copies)

Primary Care Physician: _____ Phone: _____

Address: _____

Current Pharmacy: _____ Do you plan to use one that delivers to the Community? Y / N

Food or Drug Allergies: Y / N Specify: _____

Last Hospital Admission (if less than a year): _____ Reason? _____

How many times hospitalized within past year? _____ Reason? _____

_____

Insurance Information/Company: _____

Life History Information

Birthplace: _____ Former Occupation: _____

Is Resident a Veteran or spouse of a Veteran? Y / N Religious Affiliation: _____

Church Name/Location: _____

Funeral Arrangements pre-planned? Y / N Funeral Home Information: _____

Does the Resident plan to bring a vehicle? Y / N Year: _____ Make: _____ Model: _____

Does the Resident smoke? Y / N ***SSA Communities are NON-SMOKING. Smoking is allowed in designated smoking area(s)only.***

Does the Resident wear or use:

Glasses: Y / N Hearing Aids: Y / N Right / Left

Dentures: Y / N Upper / Lower Contact Lenses: Y / N Cane / Walker / Wheelchair / Scooter

Billing Information

Who will be responsible for the following?

Laundry Services: [ ] Family Member [ ] Resident [ ] Community (charge to appear on monthly statement)

Incontinence Supplies: [ ] Family Member [ ] Resident [ ] Community (charge to appear on monthly statement)

Ancillary Products (toiletries, nutritional supplements): [ ] Family Member [ ] Resident

[ ] Community (charge to appear on monthly statement)

Billing Information (continued)

Billing Party:

Name: _____ Relationship to Resident: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____

Does this person have Power of Attorney? Y / N Type of POA: _____

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

Additional Contacts

Emergency Contact #1

Name: _____ Relationship to Resident: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____

Emergency Contact #2

Name: _____ Relationship to Resident: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____

Name of Person Completing Application (please print): _____

[ ] **Resident**

[ ] **Power of Attorney (POA)** - I have a written legal document in which I have been appointed to act as the Resident's agent on his or her behalf. My power includes signing papers, checks, handling bank accounts and other activities in the name of the Resident. As such I have the control over the Resident Funds, including their checking account, and I will use those funds to pay when due for Resident Rent, Care and Services.

[ ] **Financially Responsible** - Although I have not been appointed as the resident's power of attorney, I do have the control over the Resident Funds, including their checking account, and I will use those funds to pay when due for Resident Rent, Care and Services.

[ ] **Financial Guarantor** - I guarantee payment when due, whether from the resident's funds or my own funds, for the Resident Rent, Care and Services.

Applicant Signature: _____ Date: _____

Executive Director Signature: _____ Date: _____