Application for Residency



Disclosure

Date of Application: ___

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.

Estimated Date of Move-In: _

Apt. # (if available):	Waiting List? Y / N	Willing to take a	ternate Apt. while on wait list? Y / N
Apartment Type Desired:			Private / Shared
Basic Information			
Applicant Name:	Social Security #:		
Drivers License #:		_	
esident 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 prev	vious address:		
Previous Address:			
City:		State:	Zip Code:

Hair Color: Eye Color: Hospital of Choice: Identifying Marks: Do you have: Power of Attorney? Y / N	Wellness Information					
Do you have: Power of Attorney? Y / N	Hair Color: Eye Color: Hospital of Choice:					
Primary Care Physician: Phone: Phone: Address: Do you plan to use one that delivers to the Community? Y / N Food or Drug Allergies: Y / N Specify: Reason? Reason? How many times hospitalized within past year? Reason? Reason? Person Promer Occupation: Person Promer Occupation: Reason? Person Promer Occupation:	Identifying Marks:					
Address:	Do you have: Power of Attorney? Y / N Living Will or Advance Directives? Y / N (please provide copies)					
Current Pharmacy: Do you plan to use one that delivers to the Community? Y / N Food or Drug Allergies: Y / N Specify: Reason? How many times hospitalized within past year? Reason? How many times hospitalized within past year? Reason?	Primary Care Physician: Phone:					
Food or Drug Allergies: Y / N Specify:	Address:					
Last Hospital Admission (if less than a year):	Current Pharmacy: Do you plan to use one that delivers to the Community? Y / N					
How many times hospitalized within past year? Reason?	Food or Drug Allergies: Y / N Specify:					
Life History Information Birthplace: Former Occupation:	Last Hospital Admission (if less than a year): Reason?					
Life History Information Birthplace:	How many times hospitalized within past year? Reason?					
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: Model: 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						
Is Resident a Veteran or spouse of a Veteran? Y / N Religious Affiliation:	Life History Information					
Church Name/Location: Funeral Arrangements pre-planned? Y / N Funeral Home Information: Model: 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)	Birthplace: Former Occupation:					
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)	Is Resident a Veteran or spouse of a Veteran? Y / N Religious Affiliation:					
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	Church Name/Location:					
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Laundry Services: [] Family Member [] Resident [] Community (charge to appear on monthly statement) Incontinence Supplies: [] Family Member [] Resident [] Community (charge to appear on monthly statement)	Billing Information					
Incontinence Supplies: [] Family Member [] Resident [] Community (charge to appear on monthly statement)	Who will be responsible for the following?					
	Laundry Services: [] 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)	[] Community (charge to appear on monthly statement)					

Billing Information (continued	l)						
Billing Party:							
Name:	Re	Relationship to Resident:					
Address:							
City:							
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							
[] Resident							
[] Power of Attorney (POA) - I have a wa agent on his or her behalf. My power incl name of the Resident. As such I have the those funds to pay when due for Residen	udes signing papers, chec control over the Resident	ks, handling ban	k accounts and other activities in the				
[] Financially Responsible - Although I over the Resident Funds, including their care and Services.							
[] Financial Guarantor - I guarantee pay Resident Rent, Care and Services.	ment when due, whether	from the residen	t's funds or my own funds, for the				
Applicant Signature:		Date:					
Executive Director Signature:		Date:					