## Application for Residency

## 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 a	lternate Apt. while on wait list? Y / N
Apartment Type Desired:			Private / Shared
Basic Information			
Applicant Name:		So	cial Security #:
Drivers License #:			
Resident prefers to be called:		Referre	d by:
Date of Birth: Sex	: M / I	- Marital Status:	Single / Married / Widowed / Other
Current Address:			
City:			
Email Address:		Phone	::
If less than 2 years, please list previous address:			
Previous Address:			
City:		State:	Zip Code:

Date of Application:	E	stimated 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:		Soc	cial Security #:
Drivers License #:			
Resident prefers to be called:		Referred	d 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 previ	ous address:		
Previous Address:			
City:		State:	Zip Code:



Wellness Information	
Hair Color:     Hair Color:	
Identifying Marks:	
Do you have: Power of Attorney? Y / N Living Will or Advance Directives? Y / N (please provide co	pies)
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(	
Does the Resident wear or use:	<i>s,</i> en j.
Glasses: Y / N Hearing Aids: Y / N Right / Left	
Dentures: Y / N Upper / Lower Contact Lenses: Y / N Cane / Walker / Wheelchair / Sco	ooter
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)

[] **Community** (charge to appear on monthly statement)

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

<b>Billing Information</b>	(continued)			
Billing Party:				
Name:		Relationship to	Resident:	
Address:				
City:		State:	Zip:	
Home #:	Work #:		Cell #:	
Email Address:				
Does this person have P	ower of Attorney? Y / N T	ype of POA:		
Name:	Address:			
City:		State:	Zip:	
Emergency Contact #1 Name:		Relationship to	Resident:	
Additional Contacts	;			
·			-	
	Work #:			
Email Address:				
Emergency Contact #2				
Name:		Relationship to	Resident:	
Address:				
City:		State:	Zip:	
Home #:	Work #:		Cell #:	

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: \_\_\_\_\_

Executive Director Signature:

 Date:	
Date:	