Residency Application

Personal Information

Applicant's Name: _____

Maiden Name: _____

Address: _____

Home Phone: _____ Birth date: _____/_____/_____ Age: _____

Gender: _____ Social Security: _____/_____/_____

Name(s), address, telephone and email of nearest relative/responsible individual to assist you with this application process, and their legal capacity.

Name _____

Relationship _____

Address_____

Email _____

Telephone:_____ Cell _____

Home _____ Work _____

Legal capacity, if any._____(please attach copy of legal document)

Code Status: DNR Full Code

Name and address of primary care physician:

_____

_____

Name and address of other physician(s) and reason for this services:

_____

_____

Name and address of other physician(s) and reason for their services:

_____

_____

How do you normally get to your medical appointments?

_____

_____

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Upon acceptance into the assisted living home, an in person assessment must be completed within 90 days.

SUPPLEMENTAL INFORMATION/REFERRAL REQUIREMENTS

Do you have a legally binding POA (Power Of Attorney)?

Yes _____ No _____ (Please provide copy of document with application)

Are you living: Independently ___ With Spouse/Partner___ With Family ___ Other _____

Do you know anyone else that lives here or has lived here in the past?

_____

Have you been convicted of any felonies?

Yes _____ No _____

Are you a United States citizen?

Yes _____ No _____

Are you or your spouse a U.S. Veteran?

Yes _____ No _____

If yes, did you serve during wartime?

Yes _____ No _____

Are you legally capable of entering into a lease agreement?

Yes _____ No _____

Financial Information:

Income (All sources of regularly received money must be listed)

Social Security Gross Monthly Amount $ _____ (this includes medical insurance benefit)

Pension Gross Monthly Income $ _____

VA Benefits Gross Monthly Amount $ _____

SSI Benefits Gross Monthly Amount $ _____

Interest Income Prior Year/12 Months $ _____

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Other Monthly Income (List on back if more than one item, then put total here)

$ _____

Total Gross Monthly Income $_____

E. Financial Information: Assets Checking Accounts

Bank/Location_____ Balance $ _____

Bank/Location_____ Balance $ _____

Savings Accounts

Bank/Location_____ Balance $ _____

Bank/Location_____ Balance $ _____

Certificates of Deposits, etc.

Bank/Location_____ Balance $ _____

Trust Accounts

Bank/Location_____ Balance $ _____

Stocks, Bonds (specify)

Bank/Location_____ Balance $ _____

Other _____

Monthly amount $_____

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GENERAL CERTIFICATION

I understand that all payments owed by the applicant tenant must be made prior to occupancy. I certify that The Assisted Living Home will be my primary residence. I understand that tenant selection is based on a number of factors, primarily on the assessment of HolistiCare Home's Resident Services Assessment Team to estimate – in their best judgment – my ability to be successful in and appropriate for the assisted living home living environment. Further, I understand that my application can be rejected based on, but not limited to, poor personal references, police records indicating unacceptable or criminal behavior, and medical records indicating violent or self abuse behaviors. I also understand that if my medical condition requires it or if my behavior becomes inappropriate for the community, an extended stay in a skilled nursing facility may be indicated. I realize that if I do not meet my financial obligation and other stipulations of the group home Residency Agreement, my tenancy will be terminated. I understand that all monies owed must be paid in full prior to being allowed to move in the assisted living home. I certify that the information given in this application is true to the best of my knowledge. I understand that any false information could be grounds for cancellation of the application or termination of residency after occupancy.

Applicant _____ Date _____

Applicant's Power of Attorney _____ Date _____

RELEASE OF INFORMATION AUTHORIZATION

I hereby authorize HolistiCare Homes, Inc. and its staff to obtain any information or materials deemed necessary to determine my eligibility for housing, including contacting agencies, offices, groups or organizations, which may provide information that could substantiate or verify information given in this application (i.e. local police departments, welfare agencies or senior service agencies)

Applicant _____ Date _____

Applicant's Power of Attorney _____Date _____

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MEDICAL HISTORY QUESTIONAIRRE

Please indicate primary diagnosis:

_____

Significant past medical history:

_____

_____

_____

_____

_____

Present cognitive status (including by way of example and not limitation) confusion, long and short-term memory, depression, etc.

_____

_____

_____

Is applicant oriented to: Time: _____ Place: _____ Person: _____

Please describe any behavioral concerns, which might help us in our service planning:

_____

_____

_____

_____

Present psychosocial status:

_____

_____

_____

_____

_____

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Present physical health status:

_____

_____

_____

_____

Current medication(s):

_____

_____

_____

_____

Any known drug reactions:

_____

_____

_____

Is Applicant able to follow your prescribed medical regime(s): Yes: o No: o If no, please explain:

_____

_____

TB Test: Yes: o No: o Date: _____ Result: _____

Please describe any sensory impairment: Vision:

_____

_____

Hearing:

_____

_____

Has the Applicant suffered from any illness during the past five years that would impair his/her health Physically? Yes: o No: o If yes explain:

_____

Cognitively? Yes: o No: o If yes explain: _____

Psychosocially? Yes: o No: o If yes explain: _____

Hospitalization(s) during the past five years? Yes: o No: o If yes explain: _____

_____

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_____

_____

Is the Applicant on a special diet? Yes: o No: o If yes please explain any dietary restrictions and how we might comply: _____

_____

_____

Please indicate the Applicant's need for assistance with activities of daily living:

_____

_____

_____

_____

_____

Will the Applicant need any of the following appliances or durable medical equipment?

Walker: Yes: o No: o

Cane: Yes: o No: o

Wheelchair: Yes: o No: o Other equipment (please specify):

_____

Please identify any other special needs the Applicant may require, and how they might be accommodated:

_____

_____

_____

_____

_____

Your answers to the following questions will help plan for the Applicant once he/she has moved into our community.

Has the Applicant had any of the following diseases or disorders?

Please circle yes or no.

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If yes, please provide any additional information, which will aid in our service planning for the Applicant. Heart Disease: Yes No _____ Infarcts: Yes No _____
Angina: Yes No _____ Stroke: Yes No _____
Emphysema: Yes No _____ Paralysis: Yes No _____

Diabetes Yes No _____ Epilepsy: Yes No _____

Cancer: Yes No _____ Hip Fracture(s) Yes No _____

Urinary Problems Yes No _____ Incontinence Yes No _____

Hernias: Yes No _____ Arthritis: Yes No _____

Allergies: Yes No _____ Skin Conditions: Yes No _____
Hemorrhages: Yes No _____ Aphasia: Yes No _____
Communicable Disease HX: Yes No _____
Emergency Assist: Yes No _____
Additional Comments:

_____

_____

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