



## 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 \_\_\_\_\_ Date of Birth \_\_\_\_\_

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?

\_\_\_\_\_  
\_\_\_\_\_



## Residency Application

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?

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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 \$ \_\_\_\_\_



## Residency Application

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 \$ \_\_\_\_\_



## Residency Application

### 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 \_\_\_\_\_



# Residency Application

## MEDICAL HISTORY QUESTIONNAIRE

Please indicate primary diagnosis:

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Significant past medical history:

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

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Is applicant oriented to: Time: \_\_\_\_\_ Place: \_\_\_\_\_ Person: \_\_\_\_\_

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

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Present psychosocial status:

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## Residency Application

Present physical health status:

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Current medication(s):

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Any known drug reactions:

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

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TB Test: Yes:  No:  Date: \_\_\_\_\_ Result: \_\_\_\_\_

Please describe any sensory impairment: Vision:

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Hearing:

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

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Cognitively? Yes:  No:  If yes explain: \_\_\_\_\_

Psychosocially? Yes:  No:  If yes explain: \_\_\_\_\_

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

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## Residency Application

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Is the Applicant on a special diet? Yes:  No:  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:  No:

Cane: Yes:  No:

Wheelchair: Yes:  No:  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.

