



APPLICATION FOR ADMISSION

Date: _____

PROGRAM (Check one): _____ **Independent Living (IL)** _____ **IL with Assistance**
_____ **Choices for Independence (HCBC)** _____ **Memory Care (The Seasons)**

I. How did you learn about Summercrest? _____

II. General Information

Name _____

Age _____ Birthdate _____ Gender _____ Social Security # _____

Home address _____

Phone Number _____ Marital Status _____

Spouse's Name _____

Age _____ Birthday _____ Gender _____ Social Security # _____

[Please provide a copy of a birth or baptismal certificate with application]

In an emergency, whom should we contact?

Primary Contact Name _____ Relationship _____

Address _____ Email _____

Day Phone _____ Night Phone _____ Cell Phone _____

Secondary Contact Name _____ Relationship _____

Address _____ Email _____

Day Phone _____ Night Phone _____ Cell Phone _____

Primary Physician's Name _____

Address _____ Phone Number _____

Applicant's physical characteristics

Does applicant have need for an accessible/barrier free apartment? Yes _____ No _____

Walks unassisted _____ Uses a cane _____ Uses a walker _____

Uses a wheelchair _____ If yes, can applicant transfer unassisted? _____

Please place a check mark to indicate applicant's level of ability in the following areas:

Task	Can handle alone	Need some assistance	Total Assist
Grooming/Shaving	_____	_____	_____
Dressing	_____	_____	_____
Bathing	_____	_____	_____
Mouth/Skin Care	_____	_____	_____
Toileting	_____	_____	_____
Medication Mgmt	_____	_____	_____
Escort/Mobility	_____	_____	_____
Hskg/Clothing Mgmt	_____	_____	_____

Other daily needs _____

Is applicant alert? Yes _____ No _____ Oriented to time/place? Yes _____ No _____

Is the applicant forgetful? _____ Anxious _____ Confused _____

Health Insurance

Medicare Number _____ Medicaid Number _____

Private Insurance Company Name _____ Policy Number _____

[Please provide a copy of all insurance cards.]

Does applicant have any allergies including reactions to drugs? Yes _____ No _____

If yes, please provide details _____

Does applicant have a current and activated durable power of attorney for healthcare? Yes _____ No _____

Does applicant have a living will or advance directives? Yes _____ No _____

If these documents exist, please provide copies to the facility upon acceptance. If applicant has not completed these documents, they should see their personal physician to do so.

Social History:

Current or prior occupation(s) _____

Hobbies/Special Interests _____

Religious Affiliations(OPTIONAL): _____

Social Groups that applicant belongs to or has belonged to in the past:

III. Financial Information

Is applicant responsible for managing his or her own finances? Yes _____ No _____

If no, please provide the name of responsible party:

Name _____ Relationship _____

Address _____

Day Phone _____ Night Phone _____ Cell Phone _____

Does applicant have a Power of Attorney (POA)? Yes _____ No _____

If yes, name of POA _____

Day Phone _____ Night Phone _____ Cell Phone _____

Address _____

Cash Assets: (If more than one bank, please use the back of this page or attach another).

Bank _____

Address _____

Checking Account No. _____ Balance \$ _____

Savings Account No. _____ Balance \$ _____

Certificate of Deposit No. _____ Balance \$ _____

Does applicant have stocks and bonds? Yes _____ No _____

Approximate value of securities \$ _____

Other assets _____

Does applicant own a home? Yes ____ No ____ Approximate Value \$_____

Does applicant have additional property? Yes _____ No _____

Approximate value \$_____

Monthly Income: Social Security \$_____ Pension \$_____

Disability \$_____ Interest/Dividends \$_____

Annuity Income \$_____ Life Insurance \$_____

Rental Income \$_____ Other \$_____

Total Monthly Income \$_____

Does applicant have Long Term Care Insurance? Yes ____ No _____

List the type and value of any assets applicant has disposed of in the last two years (use additional sheet, if necessary):

Type: _____ Value: \$_____

Type: _____ Value: \$_____

I understand and agree that this application is neither a contract nor a reservation for residency. Nothing contained in this document is legally binding on either Summercrest or me until a Residency Agreement (Lease) has been signed and approved by both parties. In addition, acceptance for admission does not constitute acceptance into the Choices for Independence (formerly named Home and Community Based Care) program, which may have separate criteria for admission.

I certify that the information I have given in this application is true and correct. Summercrest is required to verify the income and assets for all applicants to the HOME program prior to acceptance and admission. I understand that any false statements or misrepresentations or omissions may result in the cancellation of my application or nullification of my residency agreement.

RELEASE OF INFORMATION

I authorize Summercrest to conduct a review of my financial status and obtain information necessary to verify my ability to pay for residency. I further agree to notify Summercrest in writing of any substantial change in my (applicant's) financial or medical condition.

I give permission to Summercrest and its contracted home care agency to request and receive health information from my health care providers and medical facilities pertinent to a health assessment prior to admission.

Summercrest agrees to keep this information strictly confidential.

Applicant's Signature _____ Date _____

If someone other than the applicant is completing this form for residency, please print the name of the person completing the information, state the relationship to the applicant, and sign on the line below.

[Please attach a copy of the Power of Attorney or other documentation authorizing a person to act on the applicant's behalf.]

Name _____ Relationship _____

Signature _____ Date _____