Summercrest
Senior Living Community

APPLICATION FOR RESIDENCY

I. GENERAL INFORMATION

Applicant Name _____

Address _____

City _____ State _____ Zip Code _____

Telephone _____ Birth Date ____/____/____

How long has applicant lived at this address? _____ ☐ Months ☐ Years Gender: ☐ Male ☐ Female

Current or former occupation _____

Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Other _____

In an emergency, who should we call?

Name _____

Address _____

Telephone _____ Relationship _____

Advance Directives

Has applicant completed a living will or advanced directive? ☐ Yes ☐ No

(*If yes, please provide us with a copy of the documents)*

Has applicant made a decision about DNR (do not resuscitate) orders? ☐ Yes ☐ No

(If yes, please provide a copy)

II. CURRENT LIVING SITUATION

Do you currently own your own home or rent? ☐ Own ☐ Rent

What type of housing do you live in? ☐ House ☐ Assisted Living ☐ Private Apt. in Senior Housing
☐ Residential Care Home ☐ Nursing Home ☐ Other

Current monthly rental rate _____

If rental, Name of Landlord/Owner/Manager _____

Address _____

City _____ State_____ Zip Code_____

Telephone _____

Do you own an automobile? ☐ Yes ☐ No Make and Year _____

Do you drive yourself regularly? ☐ Yes ☐ No Do you intend to maintain a car? ☐ Yes ☐ No

Are there any problems or concerns which our staff should be aware of or any special support you might need in our community? _____

_____

Do you require someone (friend, relative or other person) to live with you now? ☐ Yes ☐ No

If yes, who: _____ Reason for this need? _____

If not, do you require someone to visit you during the day? ☐ Yes ☐ No

If yes, reason for a visit? _____ How long is a visit? _____

Are you considering other housing alternatives? ☐ Yes ☐ No

If so, which ones? _____

III.MEDICATION INFORMATION AND INSURANCE

Primary Care Provider's Name _____

Address _____ Telephone _____

Hospital Affiliation _____

Secondary or Other Physician's Name _____

Address _____ Telephone _____

Hospital Affiliation _____

How would you describe your present state of health? _____

How often do you see your doctor? _____

When was your last visit? _____

Are you on any medications now? ☐ Yes ☐ No

If yes, please specify the medication and condition being treated:

_____

_____

_____

Do you require assistance to administer the medication? ☐ Yes ☐ No

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Do you prepare your own meals? ☐ Yes ☐ No If no, who does? _____

Are you on a special or restricted diet? ☐ Yes ☐ No If yes, describe _____

How much walking do you do? _____ Do you have difficulty with stairs? ☐ Yes ☐ No

Do you use any assistance such as a cane, walker or a wheelchair? _____

Please list all of your medical insurance coverage's, including supplemental and long-term care:

_____ Policy No: _____

_____ Policy No: _____

IV. DAILY LIVING

Please use an "X" to indicate your level of ability in the following area:

	I can handle this myself	I need some assistance	Comments
Bathing			
Dressing			
Mouth or Skin Care			
Shaving or Grooming			
Toileting			
Escort/Mobility			
Medication Reminder			
Housekeeping			
Laundry			

Do you have hobbies or areas of special interest to you?

_____

_____

_____

Is there any other information we should be aware of when reviewing your health and medical concerns?

_____

_____

_____

I understand and agree this application is neither a contract, nor a reservation for residence. Nothing contained in this document is legally binding on either myself or the community to which I am applying for residency, until a Residency Agreement has been approved and signed by all parties involved.

_____ _____

Signature of Applicant Date of Application