Residential/Personal Care

Admission Application

Complete the Application in full, as background information is helpful to staff at the time of admission.

Section 1 ~ Personal/Contact Information

Name: ____

First Middle Last

Address: ______________________________ **Telephone:** ______________

City: ______________________ **State:** ______________ **Zip:** __________

SS#: ______________ **Age:** ____________ **DOB:** ______________

Birthplace: ______________________________ **Marital Status:** ______________

Spouse's Name: ______________________________

Contact Persons

Name ______________________________ **Relationship:** ______________

Address: ____

City: ______________________ **State:** ______________ **Zip:** __________

Daytime #: ______________ **Evening #:** ______________ **Cell #:** __________

Power of Attorney? Yes ___ No___

Name: ______________________________ **Relationship:** ______________

Address: ____

City: ______________________ **State:** ______________ **Zip:** __________

Daytime #: ______________ **Evening #:** ______________ **Cell #:** __________

Power of Attorney? Yes ___ No___

Name: ______________________________ **Relationship:** ______________

Address: ____

City: ______________________ **State:** ______________ **Zip:** __________

Daytime #: ______________ **Evening #:** ______________ **Cell #:** __________

Power of Attorney? Yes ___ No___

Section 1 ~ Personal/Contact Information (Continued)

Occupation & Employment

Lifetime Occupation: ____________ **Other Employment:** ____________

Spouse's Occupation: ____________

Military Background

Branch: ____________ **Years of Service:** ____________

Religion

Church/Synagogue: ____________

Contact Person: ____________

Activities Involved in: ____________

Organizations involved in (Interests/Hobbies - include both past & present):

____

____

Section 2 ~ Medical Information

General Health Information (List major health concerns): ____________

____

____

Family Physician ____________

Pharmacy ____________

Dentist: ____________

Podiatrist: ____________

Optometrist: ____________

Hosptial Preference: ____________

Emergycare number: ____________

Insurance Coverage

Medicare Number: ____________

Medicare Prescription Drug Plan: ____________

Supplemental Insurance: ____________

Supplemental Insurance Group Number: ____________

PACE Card: Yes _____ No _____

Section 3 ~ Financial Information

Current Monthly Income

	Self		Spouse	
Social Security (net)	______________	/Month	______________	/Month
Pension	______________	/Month	______________	/Month
VA Benefits	______________	/Month	______________	/Month
Guaranteed Annuities	______________	/Month	______________	/Month
Other Interest Income	______________	/Month	______________	/Month

Asset	Institution	Approximate Value	Self/Joint
Checking			
Savings			
401(k)			
CDs			
Stocks/Bonds			
Real Estate			
Life Insurance			
Other (please specify)			

Debts & Obligations

Balance	Self/Spouse/Joint
______________________________	______________
______________________________	______________
______________________________	______________

Assets disposed of in the last 3-5 years

____

____

____

Section 4 ~ Additional Information

Funeral Home ______________________________

Pre-paid Funeral Arrangements Yes ____ No ____

Phone Number: ______________________________

Date of Desired Entrance: ____/____/____

Accommodation Desired:

Studio ________

1 Bedroom ________

2 Bedroom ________

Dementia Unit ________

Personal Care Services needed? ______________________________

____

____

Additional Remarks: ______________________________

____

____

WAIVER OF RIGHTS OF PRIVACY

I understand that with the processing of this application, it is necessary that information presented herein be made known to and verified by The Sarah A. Reed Retirement Center. Inquiries are hereby authorized and all rights of privacy herein are hereby waived by me for this purpose.

CERTIFICATION OF TRUTHFULNESS

According to the best of my knowledge, the information provided in this application is complete, accurate and true.

______________________________ ____/____/____

Signature of Applicant or Responsible Party Date