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)			
CD's			
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