

Assisted Living Centers, Inc.

**RESIDENT APPLICATION FOR ADMISSION**

*Please Print – Thank you!*

**ADDRESS AND TELEPHONE INFORMATION**

Name \_\_\_\_\_

*First*

*Middle*

*Last*

Address: *Street* \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How long have you lived at this address? \_\_\_\_\_ Are you living alone? \_\_\_\_\_

Former Housing \_\_\_\_\_

*Name*

Previous Address: *Street* \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone Number: \_\_\_\_\_

**SOCIAL AND PERSONAL INFORMATION**

Age: \_\_\_\_\_ Date of Birth: *Month* \_\_\_\_\_ *Day* \_\_\_\_\_ *Year* \_\_\_\_\_

Social Security No: \_\_\_\_\_ Sex: Female \_\_\_\_\_ Male \_\_\_\_\_

Race: \_\_\_\_\_

Marital Status: Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

If Widowed or Divorced, How Long? \_\_\_\_\_

Currently Employed? \_\_\_\_\_ Occupation \_\_\_\_\_

If Retired, what was your Occupation? \_\_\_\_\_

Date last employed? \_\_\_\_\_

What is your Religious Affiliation? \_\_\_\_\_

Do you have an Advance Directive? \_\_\_\_\_

**FAMILY AND EMERGENCY CONTACT INFORMATION**

**Next of Kin:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
*Name*

**Address: Street** \_\_\_\_\_

*City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

**Home Telephone:** \_\_\_\_\_ **Work Telephone:** \_\_\_\_\_

**Cell or Car Phone:** \_\_\_\_\_ **Pager or Beeper:** \_\_\_\_\_

**Emergency Contact Person:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_  
*Name*

**Address: Street** \_\_\_\_\_

*City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

**Home Telephone:** \_\_\_\_\_ **Work Telephone:** \_\_\_\_\_

**Cell or Car Phone:** \_\_\_\_\_ **Pager or Beeper:** \_\_\_\_\_

**Name of Power of Attorney:** \_\_\_\_\_  
*Name*

**Address: Street** \_\_\_\_\_

*City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

**Home Telephone:** \_\_\_\_\_ **Work Telephone:** \_\_\_\_\_

**HEALTH AND MEDICAL INFORMATION**

**Primary Physician(s):** \_\_\_\_\_

**Address: Street:** \_\_\_\_\_

*City* \_\_\_\_\_ *State* \_\_\_\_\_ *Zip* \_\_\_\_\_

**Office Telephone(s):** \_\_\_\_\_ **Office Fax:** \_\_\_\_\_

What is your current Health Status? \_\_\_\_\_  
\_\_\_\_\_

Primary Impairment: \_\_\_\_\_  
\_\_\_\_\_

Have you been hospitalized within the past five years? \_\_\_\_\_ If yes, for what reason(s)? \_\_\_\_\_  
\_\_\_\_\_

Please list all medications that you are currently taking and their dosage and frequency:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please Place a Check mark next to the Health Problems that are currently affecting you:

- |                                    |                                       |
|------------------------------------|---------------------------------------|
| Alzheimer's _____                  | Hearing problems/aid _____            |
| Appetite/Weight loss _____         | Heart Condition _____                 |
| Arthritis _____                    | Hypertension _____                    |
| Balance difficulties _____         | Incontinence _____                    |
| Dementia or Senility _____         | Mental Confusion _____                |
| Diabetes _____                     | Seizures _____                        |
| Dizziness or lightheadedness _____ | Sleeping difficulty _____             |
| Epilepsy _____                     | Social Interaction difficulties _____ |
| Falling _____                      | Stroke _____                          |
| Headaches _____                    | Wandering Away from home _____        |

Please describe any chronic or acute health problems other than those listed above:  
\_\_\_\_\_  
\_\_\_\_\_

Do you require a Special Diet? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been treated for a Psychiatric Illness (depression, bipolar, etc.)? \_\_\_\_\_

If yes, Date(s) of Illness, Diagnosis, and Treatment: \_\_\_\_\_  
\_\_\_\_\_

---

Have you ever been treated for an addiction to any of the following substances?

Alcohol \_\_\_\_\_ Date(s) and length of treatment: \_\_\_\_\_

Drugs or medications \_\_\_\_\_ Date(s) and length of treatment: \_\_\_\_\_

Cigarettes/Tobacco \_\_\_\_\_ Date(s) and length of treatment: \_\_\_\_\_

Do you currently: Smoke cigarettes? \_\_\_\_\_ How often? \_\_\_\_\_

Drink Alcohol? \_\_\_\_\_ How often? \_\_\_\_\_

Date of last Tuberculosis (Tb) Test or Chest X-Ray \_\_\_\_\_ Type of test? \_\_\_\_\_

Results of TB test or Chest X-Ray? \_\_\_\_\_ Testing Facility? \_\_\_\_\_

### **PERSONAL CARE INFORMATION**

Do you have and Physical Limitations that restrict your activities? \_\_\_\_\_ If yes, please Explain:

---

Do you require assistance with Walking? \_\_\_\_\_ If yes, please indicate which of the following you require:

Cane \_\_\_\_\_ Walker \_\_\_\_\_ Wheelchair \_\_\_\_\_

Do you need assistance climbing up and down stairs? \_\_\_\_\_

Do you need assistance eating? \_\_\_\_\_ Do you need assistance dressing? \_\_\_\_\_

Do you need assistance toileting? \_\_\_\_\_ Do you need assistance bathing? \_\_\_\_\_

Do you prefer a Tub Bath? \_\_\_\_\_ or Shower? \_\_\_\_\_

What time of day do you usually prefer to bathe? \_\_\_\_\_

What time do you generally prefer to retire to bed? \_\_\_\_\_

Do you have trouble sleeping? \_\_\_\_\_

If yes, do you take medication to help you sleep? \_\_\_\_\_

Name of sleeping medication, dosage, and frequency: \_\_\_\_\_

Please explain any other methods that help you when you are having sleeping difficulties: \_\_\_\_\_

What time do you generally prefer to get up and out of bed? \_\_\_\_\_

Special Needs and who provides them/name of contact person: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### **SPECIAL INTERESTS**

Please list your *Favorite Things*:

Foods: \_\_\_\_\_  
\_\_\_\_\_

Snacks: \_\_\_\_\_  
\_\_\_\_\_

Activities: \_\_\_\_\_  
\_\_\_\_\_

Hobbies: \_\_\_\_\_  
\_\_\_\_\_

Music: \_\_\_\_\_  
\_\_\_\_\_

Radio Stations/Programs: \_\_\_\_\_

TV Programs: \_\_\_\_\_  
\_\_\_\_\_

Movies/Films: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is Applicant able to participate in Group Activities outside of home? \_\_\_\_\_

### **FINANCIAL INFORMATION**

What is your Monthly Income? \_\_\_\_\_

Subsidy/Type: \_\_\_\_\_ Date entered: \_\_\_\_\_

**Please write in the amount of each source of income that applies to you:**

Annuity \$ _____	Pension \$ _____
Dividends \$ _____	Retirement \$ _____
Life insurance \$ _____	Social Security \$ _____
Interest \$ _____	Supplemental Security \$ _____

**Please list any other sources and amounts of monthly income not listed above:**

\_\_\_\_\_

### **MEDICAL INSURANCE INFORMATION**

**Please write in your Insurance Policy Numbers next to all coverage that applies to you:**

Blue Cross # _____	Blue Shield # _____
Medicare # _____	Medical Assistance # _____
Medicaid # _____	Caseworker: _____
Other # _____	Other # _____

### **GENERAL INFORMATION**

**Have you ever lived in an Assisted Living Facility? \_\_\_\_\_ Date? \_\_\_\_\_**

**Length of stay? \_\_\_\_\_ Reason(s) for Leaving? \_\_\_\_\_**

**Have you ever lived in a Nursing Home? \_\_\_\_\_ Date? \_\_\_\_\_**

**Length of stay? \_\_\_\_\_ Reason(s) for Leaving? \_\_\_\_\_**

**Telephone numbers of facility or facilities: \_\_\_\_\_**

**How did you learn about Assisted Living Centers, Inc? \_\_\_\_\_**

**Have you received the *Resident's Bill of Rights* for Assisted Living Centers, Inc? \_\_\_\_\_**

**ADDITIONAL COMMENTS: \_\_\_\_\_**

---

---

---

---

I make this application to Assisted Living Centers, Inc. of my own free will and accord, with the knowledge that I am always able to change my mind. I declare the answers in this application to be true, full and complete. I understand that acceptance as a resident as at the sole discretion of Assisted Living Centers, Inc.

---

*Signature*

---

*Date*

## CONTACT FORM

### Resident

**Name:** \_\_\_\_\_

**Primary Contact Name:** \_\_\_\_\_

**Relationship to Resident:** \_\_\_\_\_

**Home Telephone Number:** \_\_\_\_\_

**Work Telephone Number:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Secondary Contact Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Relationship to Resident:** \_\_\_\_\_

**Home Telephone Number:** \_\_\_\_\_

**Work Telephone Number:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_

**Additional Contact Name:** \_\_\_\_\_

**Mailing Address:** \_\_\_\_\_

**Relationship to Resident:** \_\_\_\_\_

**Telephone Number:** \_\_\_\_\_

**E-mail Address:** \_\_\_\_\_