RESIDENT APPLICATION

Applicant Name ____ Sex Male Female

Present Address____

City________________________________ State____________Phone_________________

Birthdate____________________________ Social Security Number___________________

INSURANCE

Health Insurance Carrier_____________________________ Policy No. ________________

Agent ________________________________ Phone No. ____________________________

Medicare # ______________________________________ Part A or B or Both (Circle one)

Medicaid ________________________________ Other _____________________________

Present Health
Condition:____

____

____

Allergies: ____

Dentist: ______________________________________ Phone _______________________________

Optometrist: __________________________________ Phone _______________________________

Does applicant need assistance ………………………………..	YES	NO
Dressing?	_____	_____
Bathing?	_____	_____
Toileting?	_____	_____

Is applicant………………………………………

Cooperative?	_____	_____
Forgetful?	_____	_____
Demanding?	_____	_____
Subject to depression?	_____	_____
Subject to aggression?	_____	_____

Comments:

____

____

____

EMERGENCY INFORMATION

In case of emergency, who should we notify? Please list in order of priority.

NAME RELATIONSHIP ADDRESS PHONE

1.____

2.____

3. ____

HEALTH INFORMATION

Physician _______________________________________ Phone ________________

Address (City, state, zip) ____

Hospital Preference ____

Does applicant have a guardian? YES or NO

Does applicant have a POA? YES or NO

If yes, please explain if POA is Financial, Healthcare or Both

____

Are the POA papers activated? YES or NO

Does applicant have a living will? YES or NO

Any Additional Comments:

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PREPARERS CERTIFICATION

In completing this application, I am aware that the administration of Disch Enterprises, Ltd DBA Collinwood memory Care will rely upon, and is entitled to rely upon, the accuracy of my statements. I also understand that I may be requested to update this application when Collinwood considers it appropriate. **I DECLARE THAT THE INFORMATION GIVEN IN THIS APPLICATION IS TRUE, FULL AND COMPLETE**. I give my permission to verify information contained in this application with the applicants physician, pharmacist, and banker.

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Applicants Signature Preparers Signature

Preparer's Phone _________________________________ Date ____________________________