MARYCREST ASSISTED LIVING APPLICATION

Please Print Clearly

TODAY'S DATE: _____

PHONE NUMBER WHERE YOU MAY BE CONTACTED: _____

HOW DID YOU HEAR ABOUT US? _____

APPLICANT

NAME: _____

DATE OF BIRTH: _____

PLACE OF BIRTH: _____

SOCIAL SECURITY #:_____

MEDICARE #: _____

PRIMARY CONTACT

NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

WORK NUMBER: _____

RELATIONSHIP TO APPLICANT: _____

MEDICAID HCBS? ☐ YES ☐ NO
HCBS CASE MANAGER NAME: _____

CASE MANAGER'S PHONE #: _____

ORGANIZATION: _____ ADDRESS: _____

HOW WOULD YOU LIKE TO BE ADDRESSED? _____

RESIDENCE HISTORY

PRESENT ADDRESS _____ APT. _____ CITY _____

STATE _____ ZIP _____ HOW LONG? _____ RENT $ _____

DO YOU OWN THIS RESIDENCE? ☐ YES ☐ NO

PRIMARY PHYSICIAN'S INFORMATION

NAME _____

ADDRESS _____ CITY _____ ZIP _____

TELEPHONE NUMBER _____ FAX NUMBER _____

TYPE OF DOCTOR _____ HOSPITAL ATTACHED TO _____

SECONDARY PHYSICIAN'S INFORMATION

NAME _____

ADDRESS _____ CITY _____ ZIP _____

TELEPHONE NUMBER _____ FAX NUMBER _____

TYPE OF DOCTOR _____ HOSPITAL ATTACHED TO _____

PRIMARY EMERGENCY CONTACT

NAME _____

RELATIONSHIP TO RESIDENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE NUMBER (Hm.) _____ (Wk.) _____ (Other) _____

EMAIL ADDRESS _____

SECONDARY EMERGENCY CONTACT

NAME _____

RELATIONSHIP TO RESIDENT _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

TELEPHONE NUMBER (Hm.) _____ (Wk.) _____ (Other) _____

EMAIL ADDRESS _____

PRIMARY DIAGNOSIS

_____

_____

_____

_____

_____

_____

MEDICATION INFORMATION

Please list all medications by name and dosage:

1. _____ **2.** _____

3. _____ **4.** _____

5. _____ **6.** _____

7. _____ **8.** _____

9. _____ **10.** _____

PHARMACY INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE NUMBER _____

INCOME

Please furnish copies of current statements, benefit checks, and other assets.

SOURCE _____ PER _____ AMOUNTS $ _____

SOURCE _____ PER _____ AMOUNTS $ _____

SOURCE _____ PER _____ AMOUNTS $ _____

SOURCE _____ PER _____ AMOUNTS $ _____

ASSETS

TYPE _____ LOCATION _____ INT. RATE _____ AMOUNTS $ _____

TYPE _____ LOCATION _____ INT. RATE _____ AMOUNTS $ _____

TYPE _____ LOCATION _____ INT. RATE _____ AMOUNTS $ _____

TYPE _____ LOCATION _____ INT. RATE _____ AMOUNTS $ _____

For Information Gathering Purposes Only:

MARITAL STATUS: SINGLE ____ SEPARATED ____ DIVORCED ____ MARRIED _____

WIDOWED ____ WHEN WIDOWED _____

RACE: WHITE ____ BLACK _____ HISPANIC ____ ASIAN OR PACIFIC ISLANDER ____

AMERICAN INDIAN OR ALASKAN NATIVE _____ NATIONAL ORIGIN _____

I authorize Harmony & Serenity Residences management to obtain information regarding my medical history and/or medical records or their agents for the purposes of verifying information as part of my application to Marycrest Assisted Living.

I authorize management to conduct a criminal records check which would indicate any criminal activity that would threaten the health, safety or right to peaceful enjoyment of other residents, their guests or personnel at the property.

_____ _____

Date **Signature of Applicant**

_____ _____

Date **Signature of Responsible Party**