APPLICATION FOR ASSISTED LIVING RESIDENCY

PLEASE PRINT CLEARLY

Today's date: _______________ How did you hear about us? ____________________________________

APPLICANT INFORMATION

Full name: _________________________________ Preferred name/title: ___________________________

Primary phone number: _____________________ Email address: _________________________________

Date of birth: _____________ Place of birth: ______________________ SSN: ______________________

OPTIONAL INFORMATION

Marital status: O Single O Separated O Divorced O Married O Widowed

If married/widowed, name of spouse: ______________ If widowed, date spouse passed: ___________

Race/ethnicity: O Black O White O Hispanic O Asian or pacific islander O American Indian

O Alaskan native O Other: ________________ National origin: _________________

APPLICANT RESIDENTIAL HISTORY

Present address: ____ Apt: _______

City/state: _________________________ Zip: _________ Do you own this residence? O Yes O No

Length of residency: ________________ Monthly rent/mortgage amount: $_______________________

EMERGENCY CONTACT INFORMATION

Full name of **primary** emergency contact: ____

Address: _______________________________________ City/state: _________________ Zip: _________

Primary phone: ___________________ Work phone number: ___________________ Ext. __________

Email address: __________________________________ Relationship to applicant: _________________

Full name of **secondary** emergency contact: ____

Address: ________________________________ City/state: ______________ Zip: ________

Primary phone: ________________ Work phone number: ________________ Ext. ________

Email address: ____________________________ Relationship to applicant: ______________

PREFERRED PHYSICIAN INFORMATION

Full name of **primary** medical physician: ____

Type of doctor: ________________ Hospital affiliated with: ____________________________

Address: ________________________________ City/state: ______________ Zip: ________

Phone number: ___________________ Ext. ________ Fax number: ____________________

Full name of **secondary** medical physician: ____

Type of doctor: ________________ Hospital affiliated with: ____________________________

Address: ________________________________ City/state: ______________ Zip: ________

Phone number: ___________________ Ext. ________ Fax number: ____________________

DESIGNATED/LEGAL REPRESENTATIVE INFORMATION

Full name: ______________________________ Relationship to applicant: ________________

Primary phone: ________________ Work phone number: ________________ Ext. ________

MEDICAL HISTORY

Primary diagnosis: ____

Secondary diagnosis: ____

MEDICATION INFORMATION

	NAME OF MEDICATION	DOSAGE
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
PLEASE ATTACH SEPARATE SHEET IF NECESSARY.		

Name of preferred pharmacy: ____

Address: ______________________________ City/state: ______________ Zip: ________

Phone number: __________________ Ext. ________ Fax number: ____________________

INSURANCE INFORMATION

Medicare number: __________ Medicaid number: __________ Medicaid HCBS? O Yes O No

Name of HCBS case manager: ________________________ Organization: ______________

HCBS case manager phone number: ________________

Address: ____

APPLICANT FINANCIAL INFORMATION

	SOURCE OF INCOME	FREQUENCY	AMOUNT
1.			
2.			
3.			
4.			
5.			
PLEASE FURNISH COPIES OF CURRENT STATEMENTS, BENEFIT CHECKS, AND OTHER APPLICABLE ASSETS.			

	TYPE OF ASSET	LOCATION	INTEREST RATE	AMOUNT
1.				
2.				
3.				
4.				
5.				
PLEASE FURNISH COPIES OF CURRENT STATEMENTS, BENEFIT CHECKS, AND OTHER APPLICABLE ASSETS.				

AGREEMENT TO APPLY FOR RESIDENCY AT MARYCREST ASSISTED LIVING

I, ______________________________, authorize the management or affiliated agents of Harmony and Serenity Residences at Marycrest Assisted Living, D.B.A. LSS of Marycrest, LLC., to obtain information in regards to my medical history and/or medical records for the purpose of verifying information in support of this residential application.

I authorize management to conduct a background check on me which would indicate any criminal activity I may have participated in that could threaten employees, residents', and guests' health, safety and/or right to peaceful enjoyment of the premises.

Signature of applicant: ____ Date: _______________

Signature of legal representative: ________________________________ Date: _______________