



RESIDENT APPLICATION

To accelerate your acceptance and approval into our home, please fill out this form as soon as possible and return to us.

RESIDENT INFORMATION									
Last				First			M.I.	Date	
Address							Apartment/Unit #		
City				State			ZIP		
Phone ()				Alternative Phone ()					
DOB		Age	Social Security Num.				Marital Status		
Medicare #		Medicaid #		Other Ins.		Ins. #			
Person or Entity Referred By									
Emergency Contact			Relationship			Phone			
Address									
Nearest Relative			Relationship			Phone			
Address									
Hospital of Choice									

PERSON(S) RESPONSIBLE FOR FINANCIAL AFFAIRS, PAYMENT FOR CARE, LEGAL GUARDIAN, ETC.								
Name			Address			Phone		
Name			Address			Phone		
Dr.			Address			Phone		
Dent.			Address			Phone		
Other			Address			Phone		
Other			Address			Phone		

PHYSICAL/SENSORY IMPAIRMENTS AND CURRENT STATUS			
Ambulation	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Explanation:
Prosthesis	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Explanation:
Skin Care	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Explanation:
Bed Care	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Explanation:
Dentures	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Explanation:
Bowel/Bladder	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Explanation:
Special Diet Required	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Explanation:
Substance Abuse	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Explanation:
Oxygen Use	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Explanation:
Vision	YES <input type="checkbox"/>	NO <input type="checkbox"/>	Explanation:

Hearing	YES <input type="checkbox"/> NO <input type="checkbox"/>	Explanation:
Dental	YES <input type="checkbox"/> NO <input type="checkbox"/>	Explanation:
Speech	YES <input type="checkbox"/> NO <input type="checkbox"/>	Explanation:
Current Mental Status <input type="checkbox"/> Alert <input type="checkbox"/> Oriented <input type="checkbox"/> Disoriented <input type="checkbox"/> Forgetful <input type="checkbox"/> Unresponsive <input type="checkbox"/> Depressed		
Current Behavior Status <input type="checkbox"/> Cooperative <input type="checkbox"/> Belligerent <input type="checkbox"/> Combative <input type="checkbox"/> Noisy <input type="checkbox"/> Abusive <input type="checkbox"/> Passive		
Other Notes/Information:		

HISTORY AND MISCELLANEOUS			
Prior Address			
Reason for Move			
Religious Preference			
Name of Clergyman/Advisor/Pastor		Phone	
Address			
Organizations currently affiliated with			
Hobbies & Interests			
Prior Occupation			

DISCLAIMER AND SIGNATURE	
I acknowledge that the above information is current and true, and hereby authorize release of medical information in this report to Legacy Living, LLC.	
Resident Signature	Date