

THE GRANVILLE ASSISTED LIVING CENTER

Application for Residency

Date _____

I. GENERAL INFORMATION

Name _____ Maiden Name _____

Phone (_____) _____

Current Address _____

City, State, Zip _____

Date of Birth ____/____/____ Age _____

Social Security # _____ - _____ - _____ Who Receives Your Social Security Check? _____

Marital Status: Single - Married - Widowed - Divorced Sex: M or F

How did you hear about The Granville Assisted Living Center? _____

Present Living Arrangements _____
House – Apartment – Alone -- With Relatives
Other _____

Is the applicant a full time or part time student? Yes - No

Have you ever been convicted of a felony? Yes - No

Are you disabled? Yes - No

Do you smoke? Yes - No

Primary Contact for Application Process

Name _____ Relationship _____

Address _____

City/State/Zip _____

Phone (_____) _____ Work Phone (_____) _____

Power of Attorney? Yes - No **Medical Durable Power of Attorney?** Yes - No

Guardianship? Yes - No **Conservatorship?** Yes - No

*Please attach copies of documentation showing POA, guardianship, and/or conservatorship, if applicable.

II. MEDICAL INFORMATION

Diagnosis (you must include any mental illness diagnosis): _____

Allergies: _____

Prescription Medications

Non-Prescription Medications

INSURANCE INFORMATION

Medicare Number: _____

***PLEASE INCLUDE A COPY OF**

Medicaid Number: _____

YOUR IDENTIFICATION CARDS

Veteran's Administration Number: _____

HMO Provider? Kaiser Secure Horizons InnovAge Other_____

Supplemental Health Insurance Carrier: _____

Policy Number: _____

Applicant Name:_____

EMERGENCY CONTACT INFORMATION SHEET

1. Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

Work Phone: (_____)_____

E-mail address: _____

2. Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

Work Phone: (_____)_____

E-mail address: _____

3. Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

Work Phone: (_____)_____

E-Mail Address: _____

Applicant Name: _____

Physician Name: _____

Clinic Name: _____

Address: _____

City: _____

State: _____

Zip: _____

Phone Number: (_____)_____

Fax Number: (_____)_____

Hospital Preference: _____

Living Will: Yes_____ No_____ *(If yes, please attach)*

Do Not Resuscitate Order: Yes_____ No_____ *(If yes, please attach)*

Religious Preference: _____

Clergy's Name: _____

Phone Number: _____

Burial Arrangements: _____

Applicant Name:_____

III. PHYSICAL STATUS

1. Are you able to walk without assistance? Yes - No

Do you use a cane? Yes - No

Do you use a walker? Yes - No

Do you use a wheelchair? Yes - No

Explain any mobility difficulties _____

2. Are you able to bathe without assistance? Yes - No

Explain any bathing difficulties _____

3. Are you able to dress without assistance? Yes - No

Explain any dressing difficulties _____

4. Are you able to eat without assistance? Yes - No

Explain any eating difficulties _____

5. Are you able to manage your toileting needs without assistance? Yes - No

Explain any toileting difficulties _____

6. Other Information Regarding Physical Status:

Applicant Name: _____

IV. FINANCIAL INFORMATION

1. HOUSEHOLD INCOME (Please write YES or NO in every space provided below. Fill in monthly amounts as applicable.)

DO YOU RECEIVE?

<u>YES/NO</u>	<u>Income Source</u>	<u>Amount per month</u>
_____	Social Security	_____
_____	V A Pension	_____
_____	Retirement/Pension	_____
_____	Old Age Pension	_____
_____	Alimony	_____
_____	SSI	_____
_____	Rental Property	_____
_____	Other _____	_____

Please list any other sources of income: _____

2. HOUSEHOLD ASSETS (Please write YES or NO in every space provided below. List amount of asset where applicable.)

<u>YES/NO</u>	<u>Asset</u>	<u>Asset Value</u>
_____	Checking Account(s)	_____
_____	Savings Account(s)	_____
_____	Cds	_____
_____	Stocks	_____
_____	Bonds	_____
_____	IRAs	_____
_____	Installment Notes	_____
_____	Property	_____
_____	Money Market	_____
_____	Other _____	_____

Please list any other asset: _____

Applicant Name: _____

For each source of income and each asset, fill in a Verification Form (address of the institution, account number (if applicable) and your signature only) and return all of them to the office with your application.

Case Manager Name_____

Phone Number_____

County_____

I hereby certify that all information contained on this application is correct and complete to the best of my knowledge and that any misrepresentation of material will result in my being ineligible for admission.

I agree to give The Granville Assisted Living Center the authority to investigate any income and/or asset sources necessary to determine eligibility and to verify the above stated information.

Applicant's Signature

Date

Responsible Party Signature

Date

It is illegal to discriminate against any person based on race, religion, sex, national origin, familial status or handicap.

EQUAL HOUSING OPPORTUNITY

Applicant Name:_____