Application for Residence

Date: ____________________

Resident Name(s): (a) ____________________ (b) ____________________

Current Address: ____________________

City: ____________________ State: __________ Zip: __________

Home Phone: ____________________ Cell Phone: ____________________

(Please attach sheet with applicant (b)'s address if applicants do not now live at same address)

Date of birth:

(a) ____________________

(b) ____________________

Marital status:

(a) ____________________

(b) ____________________

Special interests/hobbies:

(a) ____________________

(b) ____________________

Clubs, civic organizations, memberships:

(a) ____________________

(b) ____________________

Profession (present or past):

(a) ____________________

(b) ____________________

For two residents, both applicants must circle appropriatley:

(a) I am/am not licensed to drive. I will/will not bring my car.

(b) I am/am not licensed to drive. I will/will not bring my car.

Does the applicant wear: ☐ Dentures ☐ Glasses ☐ Hearing Aids (please check where applicable)

Does the applicant use: ☐ Cane ☐ Walker ☐ Wheelchair (please check where applicable)

Please list the complete names, relationships, phone numbers and addresses of family members to be notified in case of an emergency (attach additional sheet if needed):

1. Name: ____________________ Relationship: ____________________

Home Phone: ____________________ Cell Phone: ____________________

Address: ____________________

City: ____________________ State: __________ Zip: __________

Email: ____________________

2. Name: ____________________ Relationship: ____________________

Home Phone: ____________________ Cell Phone: ____________________

Address: ____________________

City: ______________________ State: ________ Zip: ______________

Email: ______________________

3. Name: ______________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________

Address: ______________________

City: ______________________ State: ________ Zip: ______________

Email: ______________________

4. Name: ______________________ Relationship: ______________

Home Phone: ______________ Cell Phone: ______________

Address: ______________________

City: ______________________ State: ________ Zip: ______________

Email: ______________________

Choice of hospital should the need arise:

(a): ______________________ (b): ______________________

Insurance:

(a): ______________________ (b): ______________________

Policy # (a): ______________________ Policy # (b): ______________________

Medicare # (a): ______________________ Medicare # (b): ______________________

Social Security # (a): ______________________ Social Security # (b): ______________________

Durable Power of Attorney/Health Care Power of Attorney rests with (please attach a separate sheet for applicant (b) if needed:

Name: ______________________ Relationship: ______________

Address: ______________________

Home Phone: ______________ Cell Phone: ______________

City: ______________________ State: ________ Zip: ______________

Advanced Directive: ☐ yes (must need copy) ☐ no

Do Not Resuscitate (DNR): ☐ yes (must need copy) ☐ no

Church membership (please attach a separate sheet for applicant (b) if needed:

Church Name: ____

Address: ____

City: ____________________ State: ________ Zip: ____________

Pastor's Name: ____________________ Phone: ____________

Funeral Home preference (please attach a separate sheet for applicant (b) if needed):

Name: ____

Address: ____

City: ____________________ State: ________ Zip: ____________

Phone: ____________________ Pre-Paid: ☐ yes ☐ no

Responsible party to whom invoices and other correspndence should be mailed:

☐ Applicant (a) ☐ Applicant (b) ☐ Third Party

If third party:

Name: ____

Address: ____

City: ____________________ State: ________ Zip: ____________

Email: ____________________ ☐ I would like the monthly bill emailed

Entrance Fee: $1000 Paid _____Yes _____No
NON REFUNDABLE

NOTE: For this application to be complete. Generations must also receive a completed Medical History Assesment Form for each prospective resident within 30 days of admission.