Application for Residence

Date: _____

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

Current Address: _____

City: _____ State: _____ Zip: _____

Daytime Phone: _____ Evening Phone: _____

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

I/we are most interested in: ☐ Independent living ☐ Assisted Living, accomedations for one

☐ Assisted Living, accomedations for two

Date of birth:

(a) _____

(b) _____

Clubs, civic organizations, memberships:

(a) _____

(b) _____

Marital status:

(a) _____

(b) _____

Profession (present or past):

(a) _____

(b) _____

Special interests/hobbies:

(a) _____

(b) _____

For two residents, both applicants must check appropriatly:

(a) I __am __am not now licensed to drive. I__ will __will not bring my car.

(b) I __am __am not now licensed to drive. I__ will __will not bring my car.

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: _____

2. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

3. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

4. Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Choice of hospital should the need arise:

(a): _____ (b): _____

Hospitatization insurance provided by:

(a): _____ (b): _____

Policy # (a): _____ Policy # (b): _____

Medicare # (a): _____ Medicare # (b): _____

Medicaid #(a): _____ Medicaid #(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: _____

Daytime Phone: _____ Evening Phone: _____

City: _____ State: _____ Zip: _____

Advanced Directive: ☐ yes ☐ 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: _____

Entrance Fee: $800 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.