The Cottages

Preliminary Application for Residency

Thank you for your interest in *The Cottages.* In order to be considered for residency or place on our waitlist, it will be necessary to complete this preliminary application.

Location: SHAWANO___OCONTO FALLS____ ASSISTED LIVING____MEMORY CARE___

General

Applicant Name: ____

Social Security Number : ____

Birth Date: ______________________ Birth Place: __________________

Address: ____

____

Phone Number: ____

Applicant Name: ____

Social Security Number: ____

Birth Date: ______________________ Birth Place: __________________

Marital Status: M___ S___ D___ W___

Are you a Veteran of the Armed Forces? Y____ N____

If so, which branch?_______________ Years of Service:___________

Current or Former Occupation: ____________________________________

Do you own an automobile? Yes___ No___ Need a garage? Yes___ No___

Church of Choice: ____

Funeral home of choice: ____

*Emergency Contacts * Please list Power of Attorney for Health Care and Financial*

Name: ____

Address: ____

____

Phone Number: ____________________ Cell Phone: __________________

Relationship: _______________ E-Mail: ___________________________

Name: ____

Address: ____

____

Phone Number: ____________________ Cell Phone: __________________

Relationship: _______________ E-Mail: ___________________________

Name: ____

Address: ____

____

Phone Number: ____________________ Cell Phone: __________________

Relationship: _______________ E-Mail: ___________________________

Needs & Services

Please check the answer that best indicates your needs.

Housekeeping: No Assistance: ____ Assistance:____
Personal Laundry: No Assistance: ____ Assistance:____
Bathing Preference: Shower ____ Tub___ Whirlpool Spa____
No Assistance:____ Assistance: ____ Times Per Week: ____
Personal Grooming: No Assistance: ____ Assistance:____
Dressing: No Assistance:____ Assistance: ____
Walking to/from meals/activities:No Assistance:____ Cane/Walker:____ W/C:____
Night Time Checks: Not Necessary:____ Would Appreciate:____
Assistance in the Bathroom: Not Necessary: ____ Would Appreciate:____
Hearing Aids: R/L/Both? ______ Dentures:____ Uppers:____ Lowers:____
Glasses:____ Visual Problems:____

How would you rate your ability in the following area?

	Good	Fair	Poor
Emergency Awareness	____	____	____
Medication Management	____	____	____

I would like staff to help me manage my medications YES____NO____
*Medication management is delegated and supervised by a licensed RN or Pharmacist

Medical

Physician's Name:____
Address:____
Hospital Preference:____
List Current Medications:____
____
____
Last Physician Visit:____
Last Hospital Stay:___________________________ Where?______________
***TB Test: (Required 90 days prior to admission)
Flu Vaccine: Yes:____ No:____ Date:_______________
Pneumo Vaccine: Yes:____ No:____ Date:_____________
Dentist's Name:____
Last Appointment:________________
Address:____
Phone:_________________________
Eye Doctor:____
Last Appointment:________________
Address:____
Phone:_________________________

Financial

Please list your available financial resources for long term care:

Government funding sources are available if you qualify financially. Please assure list is complete so we can better advise and refer you to those that can help you afford long term care.

Cash Assets (Approximately):____

Home or Property: Own:_____ Rent:_____ Value:________________

Monthly Income:

1. Employment Income: $ /month
2. Social Security Income: $ /month
3. Pension Income: $ /month
4. Interest Income: $ /month
5. Other: $ /month

Total: $ /month

Name and Address of Medical Insurer:__________________________________

Policy Number:____

Do you have Long Term Care Insurance? Yes____ No_____

Name and Address of Long Term Care Insurer:___________________________

Policy Number:____

Are you approved for FAMILY CARE funding? Yes____ No_____

Managed Care Organization LAKELAND _____ CARE WISCONSIN _____

I understand and agree that the foregoing application is not a contract or reservation for residency. Nothing contained herein is binding on either party until a Residency Agreement has been signed by the parties.

I certify that the information which I have provided in this application is true and correct to the best of my knowledge and belief.

____

Applicant Signature Date

____

Admissions Coordinator Date

GM Approved _________date______