Application for Residency

Section One: Personal Information

Name:
_____
_____
Address:
_____
_____
Phone Number: _____ Social Security Number:
_____
Date of Birth: _____ Gender:
_____
Marital Status:
_____
_____
Name of Spouse/Partner:
_____
Do you have a living will?
_____
Name(s), Address, and Phone Number of Living Children:
_____
_____
_____
_____
_____
_____
_____
Religious Affiliation:
_____
_____
Name of Home Church:
_____
_
Address:
_____
_____
Name of Priest/Pastor:
_____
__
Responsible Party:
_____
_____

Address:
_____
_____
Phone Number(s): Home: _____ Cell: _____ Work:
_____
Emergency Contact 1: _____ Relationship:
_____
Address:
_____
_____
Phone Number(s): Home: _____ Cell: _____ Work:
_____
Emergency Contact 2: _____ Relationship:
_____
Address:
_____
_____
Phone Number(s): Home: _____ Cell: _____ Work:
_____
Emergency Contact 3: _____ Relationship:
_____
Address:
_____
_____
Phone Number(s): Home: _____ Cell: _____ Work:
_____

Additional Information:
_____
_____
_____
_____
_____
_____

Section Two: Medical Information

Name of Physician(s):
_____
___
Address:
_____
_____
Phone Number(s):
_____
_____

Do you have a history of the following?

	Yes	No		Yes	No
Allergies *(food, dust, insects, etc.)*		____	Difficulty Hearing	____	____
			Hepatitis	____	____
____			HIV/AIDS	____	____
Allergies			Hernia	____	____
(medication)	____	____	High/Low Blood Pressure	____	____
Arthritis	____	____	Hyper/Hypothyroidism	____	____
Asthma	____	____	Joint Problems	____	____
Blurred Vision	____	____	Kidney Problems	____	____
Bronchitis	____	____	Major Surgery	____	____
Cancer	____	____	Nausea/Vomiting	____	____
Dementia	____	____	Pacemaker	____	____
Dentures	____	____	Pain	____	____
Depression/Mental Illness	____	____	Respiratory Problems	____	____
Diabetes	____	____	Seizures	____	____
Dizziness/Fainting	____	____	Stomach Problems	____	____
Eyeglasses/Contacts	____	____	Tuberculosis	____	____
Headaches/Migraines	____	____			
Heart Problems	____	____			

Please explain any "Yes" responses:

_____
_____
_____
_____
_____
_____

Current Prescription Medications:

_____
_____
_____

Current Over-the-Counter Medications:

_____
_____
_____

Current Herbal Supplements:

_____
_____
_____

Section Three: Health Insurance Information

Name of Provider:

_____
_____

Address:
_____
_____
Phone Number: _____ Policy Number:
_____
Prescription Coverage? Yes _____ No _____ Medicare? Yes _____ No_____
Other Insurances:
_____
_____
_____

Section Four: Financial Information

Name: _____ Date:
_____

Income (from all sources, including but not limited to the following):

	Duration	Amount	Yearly Total
Social Security			
Pension			
Annuity			
Trust			
Rental			
Dividends			
Interest			
Bonds			
Stocks			
Certificates of Deposit			
Other Equities			
Mutual Funds			
Other			

Assets

Bank Name:
_____
_____
Type of Account: _____ Account Number: _____ Balance:
_____

Bank Name: _____

Type of Account: _____ Account Number: _____ Balance: _____

Bank Name: _____

Type of Account: _____ Account Number: _____ Balance: _____

Stocks and Bonds: _____

Real Estate: _____

Life Insurance Policy (where applicant is insured or owner):

Company: _____ Policy Number: _____

Face Value: _____ Cash Value: _____

Company: _____ Policy Number: _____

Face Value: _____ Cash Value: _____

Other Assets/Sources of Income:

_____

_____

_____

Debts (Mortgages or other obligations that may affect the income or assets):

_____

Amount: _____

_____

Amount: _____

_____

Amount: _____

Your Attorney: _____ Phone Number: _____

Address: _____

_____

Signature: _____ Date: _____

*Application must be submitted with **MA-51, DME,** and **Communicable Disease Form**, each completed by a **phyisician**.

All sections of this application must be completed.

All information provided will be kept confidential. Confidentiality is a principle of ethics according to which board members and staff of The Episcopal Home may not disclose information about a resident or application without the resident or applicant's written consent.