Maple View
MEMORY CARE COMMUNITY

CONFIDENTIAL APPLICATION FOR RESIDENCY

Today's Date:

Level of Care: ☐ Memory Care ☐ Adult Day Services ☐ Respite Care

PERSONAL PROFILE

Name:

Address:

City/State/Zip:

Phone Number: | **Social Security #:**

Date of Birth: | **Place of Birth:**

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Medicare # :

EMERGENCY CONTACT

Name: | **Relationship:**

Address: | **City/State/Zip:**

Home Phone: | **Work:** | **Cell:**

MEDICAL/EMERGENCY INFORMATION

Hospital: | **Phone:**

Physician: | **Phone:**

Clinic: | **Address:**

Pharmacy: | **Phone:**

Dentist: | **Phone:**

Opthmalogist: | **Phone:**

Diagnoses: _____

_____

_____

_____

_____

Code Level:

MEDICAL INFORMATION

Name of Primary Physician:

Address: | **City/State/Zip:**

Phone: | **Date Last Seen:**

MEDICAL INFORMATION *continued*

Current Medications (Name, dose and reason for taking):

1.
2.
3.
4.
5.

Allergies: _____

HEALTH HISTORY

Have you been hospitalized in the last year? ☐ No ☐ Yes *If so, what was the nature of your illness?* _

Do you now have or in the past have you had, any of the following medical or physical conditions or problems?

☐ Anemia	☐ Chest Pain/Angina	☐ Anxiety
☐ Heart Disease	☐ Depression	☐ Stroke
☐ Arthritis	☐ Forgetful	☐ High Blood Pressure
☐ Thyroid	☐ Dizziness	☐ Vision
☐ Asthma/Lung problems	☐ Falls	☐ Hearing
☐ Difficulty Sleeping	☐ Bladder Problems	☐ Osteoporosis
☐ Cancer	☐ Bowel Problems	☐ Seizures
☐ Bleeding Problems	☐ Stomach/Ulcers	☐ Gout
☐ Diabetes/Kidney Disease	☐ *Other* _____	

Check any of the following activities that are currently a challenge for you or that you require assistance with:

☐ Taking medications	☐ Driving	☐ Dressing
☐ Taking bath/shower	☐ Eating	☐ Using the phone
☐ Getting in/out of bed	☐ Getting into/out of chair	☐ Walking outdoors
☐ Getting on/off toilet	☐ Going up/down stairs	☐ Walking indoors
☐ Writing checks/paying bills	☐ *Others* _____	

ADDITIONAL INFORMATION

Religion:	**Church/Minister:**
POA Health Care:	**POA Finances:**
Living Will:	**Hearing Aid Service:**
Funeral Home:	**Phone Number:**

Other: _____

BILLING INFORMATION

Payment Method: ☐ Self Pay ☐ LTC Insurance Policy ☐ Medicaid

Name of Responsible Party *if other than resident*:

Address:

City:	**State:**	**Zip:**
Home Phone #:	**Work #:**	**Cell #:**

APPLICATION SUMMARY

Receipt of this Application does not commit Maple View to admit the Applicant into residency status. The decision to admit or not to admit an applicant is made by the Director and Maple View staff and will be based on the information you have provided along with an assessment at the time of the potential admission. The applicant agrees to such decision as binding and final in all respects.

The Applicant agrees to notify Maple View of any significant changes of information furnished in this Application. Furthermore, I/we agree to notify, in writing, of any future significant changes to my/our health from that which is herein provided.

I/we affirm that the foregoing family and personal information, and personal health history, are to the best of my/our information, true, correct and complete, and that such information may be reviewed by Maple View for the purpose of determining whether or not the undersigned is/are accepted as resident(s).

Applicant Signature:	**Date:**
Maple View Personnel Signature:	**Date:**