



Resident Application

Please complete this form as soon as possible to ensure prompt processing of your application.

RESIDENT INFORMATION

Date _____
Last _____ First _____ M.I. _____
Address _____ Apt.#/Unit _____
City _____ State _____ Zip _____
Phone () _____ Alternate Phone () _____
DOB _____ Age _____ Social Security # _____ - _____ - _____
Marital Status: **S M D W**
Person or Entity Referred By _____
Address _____ Phone () _____

EMERGENCY CONTACT INFORMATION

Name _____ Relationship _____
Address _____ Phone () _____
Name _____ Relationship _____
Address _____ Phone () _____
Name _____ Relationship _____
Address _____ Phone () _____

Hospital of Choice _____

PERSON(S) RESPONSIBLE FOR FINANCIAL AFFAIRS, PAYMENT FOR CARE, LEGAL GUARDIAN, ETC.

Name _____
Address _____ Phone _____

Name _____
Address _____ Phone _____

OTHER CONTACTS

Dr. _____ Address _____ Phone _____
Dent. _____ Address _____ Phone _____
Other _____ Address _____ Phone _____
Other _____ Address _____ Phone _____

PHYSICAL/SENSORY IMPAIRMENTS AND CURRENT STATUS

Ambulation	Y	N	Explanation: _____
Prosthesis	Y	N	Explanation: _____
Skin Care Requirements	Y	N	Explanation: _____
Dentures	Y	N	Explanation: _____
Bowel/Bladder	Y	N	Explanation: _____
Special Diet Requirements	Y	N	Explanation: _____
Substance Abuse	Y	N	Explanation: _____
Oxygen Use	Y	N	Explanation: _____
Vision Impairment	Y	N	Explanation: _____
Hearing Impairment	Y	N	Explanation: _____
Dental	Y	N	Explanation: _____
Speech Impairment	Y	N	Explanation: _____

Current Mental Status: ___ Alert/Oriented ___ Disoriented ___ Forgetful ___ Unresponsive
___ Depressed

Current Behavioral Status ___ Cooperative ___ Belligerent ___ Combative ___ Noisy ___ Abusive
___ Passive

Other Notes/Pertinent Information:

HISTORY AND MISCELLANEOUS

Prior Location _____
Reason for Move _____

Religious Preference _____
Name of Clergyman/Advisor/Pastor _____ Phone () _____
Address _____

Organizations currently affiliated with _____

Hobbies and Interests _____

Prior Occupation _____

DISCLAIMER AND SIGNATURE

I, the resident, acknowledge that the above information is current and true, and hereby authorize release of medical information in this report to Grand Living.

Signature of Resident or Legal Guardian

Date

To be completed by office personnel: Date of residency _____

Received \$750.00 entrance fee _____