

Potential Resident's Name: \_\_\_\_\_

Current Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone Number: (      ) \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Do you have Supplemental Insurance?  Yes  No

If yes, name and group number: \_\_\_\_\_

Do you have an HMO?  Yes  No

If yes, name and group number: \_\_\_\_\_

Do you have long term care insurance?  Yes  No Name: \_\_\_\_\_

Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you or your family hear about Selfhelp Home? \_\_\_\_\_

**Your Personal History:**

Marital status?  Single  Married  Widowed  Divorced

Where were you born?

City: \_\_\_\_\_ Country: \_\_\_\_\_

If married or widowed, where was your spouse born?

City: \_\_\_\_\_ Country: \_\_\_\_\_

Where did you live before you immigrated (if applicable)?

City: \_\_\_\_\_ Country: \_\_\_\_\_

When did you arrive in the U.S.? \_\_\_\_\_

**Current Residence:**

Are you currently living alone?  Yes  No

If no, who are you living with?

Spouse  Relatives  Other (Specify): \_\_\_\_\_

Do you...  Own or  Rent?

Are you living in...  An Apartment  Own Home

Retirement/Nursing Facility (Specify): \_\_\_\_\_

## ***About Potential Resident:***

What was your occupation? \_\_\_\_\_

Do you have a living will?  Yes  No

Who is your Power of Attorney for health care?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Who is your Power of Attorney for your property?

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

If help is needed or in an emergency, person to contact is:

1.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

2.) Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Home Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

## ***Preferred Accommodations at Selfhelp:***

Choice of residence?  Independent Living  Assisted Living  Nursing Home

*If Retirement/Assisted Living, choice of accommodations:*

Studio Residence  One Bedroom Residence

Choice of meal service?  Three Meals Daily  One Meal Daily

When would you like to move to Selfhelp? \_\_\_\_\_

Donation to Selfhelp: Amount \$ \_\_\_\_\_

Has any member of your family been a resident of Selfhelp?  Yes  No

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Are you a member of Selfhelp?  Yes  No

Have you recently visited Selfhelp?  Yes  No If yes, date of visit: \_\_\_\_\_

**Medical Information:**

Physician's name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

Do you have any other consulting physicians?  Yes  No

If yes, please list physician's name below:

Dentist \_\_\_\_\_ Audiologist \_\_\_\_\_

Ophthalmologist \_\_\_\_\_ Cardiologist \_\_\_\_\_

Pulmonologist \_\_\_\_\_ Neurologist \_\_\_\_\_

Rheumatologist \_\_\_\_\_ Gastroenterologist \_\_\_\_\_

Psychiatrist \_\_\_\_\_ Other \_\_\_\_\_

Have you been hospitalized within the last year?  Yes  No

If yes, please list what hospital, date of hospitalization and reason \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you currently taking any medication?  Yes  No

If yes, please list medication, frequency, and dosage: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any dietary restrictions?  Yes  No If yes, what are they? \_\_\_\_\_

Are you currently using any assistive devices?  Yes  No If yes, please check below:

Walker  Wheel Chair  Glasses  Cane  Hearing Aid  Other \_\_\_\_\_

Have you received a flu vaccination?  Yes  No If so, when? \_\_\_\_\_

Have you received a pneumonia vaccination?  Yes  No If so, when? \_\_\_\_\_

Have you received a TB test?  Yes  No If so, when? \_\_\_\_\_

Other pertinent medical information:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Your Signature: \_\_\_\_\_ Today's Date: \_\_\_\_\_

**Annual Income**

**Best Estimate**

Pension Income

    Social Security \$ \_\_\_\_\_

    Retirement Pension, Insurance \$ \_\_\_\_\_

    Other Pension \$ \_\_\_\_\_

Work Income ... Employment, Business, Professional \$ \_\_\_\_\_

Dividends and Interest \$ \_\_\_\_\_

Other Income (Specify \_\_\_\_\_ ) \$ \_\_\_\_\_

Support from Relatives \$ \_\_\_\_\_

    Name \_\_\_\_\_

**Total** \$ \_\_\_\_\_

**Financial Resources**

Cash in Checking, Money Market, and Savings Accounts \$ \_\_\_\_\_

Estimated Value of Residential or Other Real Estate Property Less Mortgages \$ \_\_\_\_\_

Investment in Mutual Funds, Stocks, etc. \$ \_\_\_\_\_

Other (Specify \_\_\_\_\_ ) \$ \_\_\_\_\_

**Total** \$ \_\_\_\_\_

FOR OFFICE USE ONLY

Received by: \_\_\_\_\_ Date: \_\_\_\_\_

Approved by: \_\_\_\_\_ Date: \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

