This application is a fillable PDF. Complete the form by typing the required information in to the form fields. Begin by clicking on the first field below: APPLICANT'S NAME. Press the tab key to move forward. Shift/Tab moves you backward, or you can click on any field to enter info. Save and print your completed application. Be sure to sign and date on the last page after printing.

APPLICANT'S NAME:_____

DATE:_____

APPLICATION FOR RESIDENT
and
RESIDENT PROFILE

ST. ANDREWS VILLAGE
RETIREMENT COMMUNITY

PLEASE CHECK WHICH AREA(s) APPLYING FOR:

__ Assisted Living

__ Gregory Wing Long-Term Nursing Care

__ Safe Havens Memory Care

IDENTIFICATION SUMMARY (CONFIDENTIAL)

Applicant Name: Last First MI Sex Religion

Usual Residence: Street Home Phone Birthdate Age

City/Town State County Zip Code Marital Status Is spouse living?

Social Security Number Place of Birth Citizen of what county?

Spouse's Name Address Phone Number

HEALTHCARE PROVIDERS

Attending Physician _____ Address _____ Phone # _____

Alternate Physician _____ Address _____ Phone # _____

Dentist _____ Address _____ Phone # _____

Eye Doctor/Optometrist _____ Address _____ Phone # _____

INSURANCE INFORMATION

Responsible Party Address Phone # Relationship

METHOD OF PAYMENT: Private Medicaid If Medicaid, has an application been made? Yes No

I.D. # _____

Medicare # BC/BS Number and Coverage

Other/Secondary Insurance Name

ADVANCE DIRECTIVES

Do you have a LIVING WILL? Y N Healthcare Proxy? Y N Healthcare Power of Attorney? Y N

MILITARY HISTORY

Have you served in the U.S. Armed Forces? _____ Unknown _____ Branch _____ Dates of Service _____

OTHER

Church or Synagogue Address Phone #

Funeral Home to Notify Address Phone #

Education Level (circle one) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Other Occupation _____

Referred By/How did you hear about St. Andrew's Village? _____

MEDICAL SUMMARY

Primary Diagnosis: _____

Secondary Diagnosis: _____

Allergies: _____ Current Medications: _____

Additional Space if Needed _____

PREVIOUS HOSPITAL ADMISSIONS

Admission Date _____ Discharge Date _____ Facility _____ Reason for Admission _____

Admission Date _____ Discharge Date _____ Facility _____ Reason for Admission _____

Admission Date _____ Discharge Date _____ Facility _____ Reason for Admission _____

PREVIOUS LONG TERM CARE ADMISSIONS

Name and address of doctors and/or specialists Applicant has seen during the past two years. Please list all medical doctors, eye specialists, speech therapists, oral surgeons, podiatrists, psychiatric stays and rehab stays.

NAME/ADDRESS SPECIALITY

1. _____
2. _____
3. _____

PLEASE ARRANGE TO HAVE ONE OF THE FOLLOWING SENT TO US: Hospital Discharge Summary or Recent Medical Examination.

FAMILY SUPPORT FACILITIES

Please list name, address and telephone number of family members, significant others, etc.

1. _____
2. _____
3. _____
4. _____
5. _____

Name, address and telephone numbers of children.

1. _____
2. _____
3. _____

What is the Applicant's primary language? _____

Does the Applicant speak any other languages? _____

Is the Applicant a registered voter? _____ Will he/she wish to vote? _____

Upon whom does the Applicant rely on most?

_____

Name Address

In the event of a doctor's appointment, who should be contacted for transportation of Applicant?

1. Name: _____ Phone #: _____

2. Name: _____ Phone #: _____

Present Living Arrangements and Care Requirements:

In home Apartment Boarding Home/Assisted Living Hospital Friends/Relatives

Other: _____

_____

_____

INDIVIDUAL CHARACTERISTICS

Type of diet while at home? _____

List any food allergies: _____

Food/Likes: _____

Food/Dislikes: _____

What is the Applicant's usual retiring time? _____

How long does the Applicant usually sleep? _____

Does Applicant take naps during the day? _____

Does the Applicant awaken during the night? _____ What generally helps promote sleep? _____

Does the Applicant appear confused during the night? _____

Does Applicant have difficulty with:

SPEECH	FEEDING	TOILET
HEARING	AMBULATION	BOWEL - Usual Pattern _____
DRESSING	BATHING	BLADDER - Usual Pattern _____
OTHER, Please Specify: _____		

Are there any behavior concerns? Yes No Explain _____

THIS IS A NON-SMOKING FACILITY

Use of alcoholic beverages?	Yes	No	Any history of alcohol abuse?	Yes	No
History of mental illness?	Yes	No	History of intellectual disability	Yes	No

What has Applicant been told about placement? _____

What was the Applicant's reaction? _____

What was the Applicant's reaction to the facility? _____

_____

What has the Applicant been told about his/her diagnosis and/orprognosis? _____

What was the reaction? _____

Who or what was the most influential in making the final decision in seeking placement? _____

_____

Has the Applicant used any community resources or agencies while living at home? _____ Yes No

If yes, please explain _____

Does the Applicant prefer being alone or group activities? _____

Applicant's hobbies and/or interests? _____

Name of clubs & organizations to which the Applicant belongs or has belonged to in the past? _____

DISCHARGE PLAN;

Do you consider this long-term or temporary placement? _____

All residents have discharge planning initiated on admission, taking into account the Resident's individual care needs & prognosis. In the event the Applicant improves significantly to be discharged, have any tentative plans been made for living arrangements? Yes No

Who will be involved in the planning? _____

Estimated length of stay at St. Andrews Village? _____

Applicant's Signature	Informant's Signature	Relationship to Applicant	Date