

	ANTONINE VILLAGE Administration Form	Code: ADM-FR-5	Page 1 of 4
	Resident Application	Approval date: 12/01/2014	Revision date:

Applicant Information		
Are you applying for <input type="checkbox"/> Suite <input type="checkbox"/> Assisted Living (AL) <input type="checkbox"/> Memory Care (MC)		
Last Name:	Middle:	First:
Date of birth: / /	Place of birth:	Gender: <input type="checkbox"/> F <input type="checkbox"/> M
Current address:		Phone: ()
City:	State:	ZIP Code:
Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> Religious <input type="checkbox"/> Priest		Veteran: <input type="checkbox"/> Yes <input type="checkbox"/> No
Name of Spouse		Phone: ()
Address of Spouse		Cell Phone: ()
City:	Zip Code:	Social Security #:
Medicaid:	Medicare:	Insurance
Names of children and/or interested persons		
Responsible Party:		
Relationship:		E-mail:
Phone: ()	Cell phone: ()	Fax:
Address		
City:	State:	ZIP Code:
Name of Emergency Contact #1:		
Relationship:		E-mail:
Phone: ()	Cell phone: ()	Fax:
Address		
City:	State:	ZIP Code:
Name of Contact # 2:		
Relationship:		E-mail:
Phone: ()	Cell phone: ()	Fax:
Address		
City:	State:	ZIP Code:
Name of Contact # 3:		Relationship:
Home Phone: ()	Work Phone: ()	Cell phone: ()
Address		E-mail:
City:	State:	ZIP Code:

Does the applicant have a:	
Power of attorney for Health Care? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone: ()
Power of attorney for financial needs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone: ()
Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone: ()
Court Appointed Guardian? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name: Phone: ()

Physician		
Present Attending Physician:		
Address:		
City:	State:	ZIP Code:
Phone: ()	E-mail:	Fax:
Will this physician continue to care for the resident? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If not, can arrangements be made by the nursing staff for the services of one of the physicians at the Antonine Village? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Hospital Preferred:		
Pharmacy used in community:		

Reason for applying to Antonine Village:

How did you hear about Antonine Village?
<input type="checkbox"/> Friend or relative <input type="checkbox"/> Sign <input type="checkbox"/> TV <input type="checkbox"/> Radio <input type="checkbox"/> Newspaper ad or articles <input type="checkbox"/> Other: _____

Activities for daily living:

Has he/she been diagnosed with Dementia/Alzheimer's Disease by a physician? Yes No

AMBULATION

Walks alone Transfers alone Uses walker Uses cane Independent in wheelchair

Other: _____

EATING Feeds self Needs assistance Adaptive equipment needed: _____

HEARING Adequate Adequate with aid Poor Deaf

VISION Adequate Adequate with glasses Poor Blind

COMMUNICATION Normal speech Foreign language/accents: _____

Communication deficit: _____

INTERACTION WITH OTHERS

Friendly Anxious Quiet Other: _____

Do you understand and agree to the following provisions:

1. Applicants must be capable of maintaining relative independence in their daily living with only limited assistance needed with personal care.	Yes	No
2. The resident's medications would be purchased at a pharmacy utilized by Antonine Village and paid for by the resident or insurance.	Yes	No
3. Payment must be made upon receiving the statement of charges which will be sent the first week of the month.	Yes	No
4. Charges may be adjusted at times according to the care required by the resident and/or other necessary reasons.	Yes	No
5. Residence at Antonine Village is subject to Assisted Living licensure regulations and requirements of the State of Ohio and may be revised at times.	Yes	No
6. Payment for one week will be charged if a resident leaves without giving at least one week notice.	Yes	No
7. Antonine Village will give a 30 day notice if a resident is asked to leave.	Yes	No
8. Residents will move into a health care facility of their choice, if in the judgment of their physician, their needs can no longer be met in the Antonine Village.	Yes	No

I HEREBY APPLY FOR ADMISSION as a resident and agree to the above mentioned terms.

I affirm that the information contained in this application is correct to the best of my knowledge and is submitted as part of my application for residency. I understand that additional information may be requested in the future. I agree to notify the administrative office in writing of any significant changes in the information contained herein.

I hereby authorize any physician or health treatment facility to release medical information that is requested for purposes of evaluating my application for residency.

I am aware that information submitted in this application process will be held in strict confidence. Upon approval for residency, all data will become part of my permanent and confidential record.

Applicant's Name _____

Responsible party Signature _____

Date _____