ALVARIUM PERSONAL CARE, LLC

APPLICATION FOR RESIDENCE

Personal and Confidential

SECTION I: RESIDENT DEMOGRAPHICS		
RESIDENT NAME: Last, First, Middle Initial		SOCIAL SECURITY NUMBER:
SEX:	DATE OF BIRTH:	MARITAL STATUS:
CURRENT ADDRESS: (Street, City, State, Zip Code)		PHONE #:
PREVIOUS ADDRESS: (Street, City, State, Zip Code)		
POTENTION RESIDENTS ATTITUDE TOWARD PLACEMENT:		
☐ Agreed ☐ Undecided ☐ Negative		

SECTION II: MEDICAL INSURANCE		
MEDICARE NUMBER:	PRESCRIPTION PLAN (NAME):	PRESCRIPTION PLAN NUMBER:
OTHER INSURANCE (NAME):	OTHER INSURANCE POLICY NUMBER:	

SECTION III: EMERGENCY CONTACT INFORMATION	
NAME:	RELATIONSHIP
CURRENT ADDRESS: (Street, City, State, Zip Code)	TELEPHONE NUMBER:
NAME:	RELATIONSHIP
CURRENT ADDRESS: (Street, City, State, Zip Code)	TELEPHONE NUMBER:
NAME:	RELATIONSHIP
CURRENT ADDRESS: (Street, City, State, Zip Code)	TELEPHONE NUMBER:

SECTION IV: POWER OF ATTORNEY	
NAME:	TELEPHONE NUMBER:
ADDRESS: (Street, City, State, Zip Code)	

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SECTION V: PHYSICIAN INFORMATION	
PRIMARY CARE PHYSICIAN	**TELEPHONE NUMBER:**
ADDRESS: (Street, City, State, Zip Code)	
PHYSICIAN NAME	**SPECIALTY:**
CURRENT ADDRESS: (Street, City, State, Zip Code)	**TELEPHONE NUMBER:**
PHYSICIAN NAME	**SPECIALTY:**
CURRENT ADDRESS: (Street, City, State, Zip Code)	**TELEPHONE NUMBER:**
PREFERRED HOSPITAL:	**PREFERRED AMBULANCE:**

SECTION VI: REFERRING AGENCY	
REFERRING AGENCY:	
HOW DID YOU HEAR ABOUT US:	
☐ Radio ☐ Family/Friend ☐ Advertisement _____ ☐ Other_____	
ADDRESS: (Street, City, State, Zip Code)	**TELEPHONE NUMBER:**
RESIDENT PRESENTLY RESIDING:	**CASE WORKER:**
ATTENDING PHYSCIAN:	**TELEPHONE NUMBER:**
PRIMARY DIAGNOSIS	**SECODNARY DIAGNOSIS:**

SECTION VII: MOBILITY			
FULLY AMBULATORY:	**WHEELCHAIR:**	**WALKER:**	**CANE:**
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

SECTION VIII: ACTIVITIES OF DAILY LIVING SKILLS	
BATHING	**DRESSING**
☐ INDEPENDENT ☐ ASSISTANCE ☐ TOTAL CARE	☐ INDEPENDENT ☐ ASSISTANCE ☐ TOTAL CARE

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FEEDING	INCONTINENCE
☐ INDEPENDENT ☐ ASSISTANCE ☐ TOTAL CARE	☐ BOWEL ☐ BLADDER ☐ CATHETER

SECTION IX: MENTAL STATUS

☐ ALERT ☐ WANDER ☐ CONFUSED ☐ OTHER: _____

SECTION X: DISABILITIES

☐ PARALYSIS Location: _____ ☐ VISION ☐ HEARING ☐HEARING AIDS

☐ DENTURES ☐ GLASSES ☐ DIABETIC

SECTION XI: THERAPY

☐ OCCUPATIONAL	☐ PHYSICAL	☐ SPEECH	OXYGEN REQUIRED ☐ YES ☐ NO

SECTION XII: APPLIANCES

☐ Colostomy ☐ Prosthesis ☐ Pacemaker ☐ Catheter ☐ Other: _____

SECTION XIII: MEDICAL HISTORY

CURRENT MEDICATIONS AND TREATMENT:

ALLERGIES: (food and drug):

SURGICAL HISTORY:

SURGERY:		**DATE:**	
SURGERY:		**DATE:**	
SURGERY:		**DATE:**	
SURGERY:		**DATE:**	

MEDICAL HISTORY AND ABNORMAL FINDINGS: *(if checked, please specify)*

☐	ALCOHOL/DRUG USE	☐	GALL BLADDER DISEASE	☐	PARKINSON'S DISEASE
☐	ALZHEIMER'S/DEMENTIA	☐	GASTROINTESTINAL DISORDERS	☐	POLIO
☐	ANEMIA	☐	HAY FEVER	☐	RESPIRATORY DISEASE
☐	ARTHRITIS OR RHEUMATISM	☐	HEADACHES	☐	RHEUMATIC FEVER
☐	BLINDNESS	☐	HEART TROUBLE	☐	SKIN PROBLEMS
☐	BLADDER INCONTINENCE	☐	HEPATITIS	☐	STROKE
☐	BOWEL INCONTINENCE	☐	HIGH BLOOD PRESSURE	☐	SMOKING
☐	BLOOD DISORDERS	☐	INFECTIOUS DISEASE	☐	TUBERCULOSIS
☐	CANCER	☐	KIDNEY DISEASE	☐	URINARY TRACT INFECTION
☐	CEREBRAL PALSY	☐	LIVER DISEASE	☐	VENEREAL DISEASE
☐	DIABETES	☐	MENTAL ILLNESS	☐	WIGHT LOSS – SIGNIFICANT
☐	EMPHYSEMA	☐	MENTAL RETARDATION	☐	WEIGHT GAIN – SIGNIFICANT
☐	EPILEPSY (SEIZURES)	☐	MULTIPLE SCLEROSIS	☐	FAINTING SPELLS
☐	OTHER: _____				

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MENTAL FUNCTIONING:			
☐	ANXIETY, PHOBIAS, PANIC ATTACKS, EXCESSIVE FEARS	☐	PREOCCUPATION WITH PHYSICAL HEALTH
☐	OBSESSIVE-COMPULSIVE DISORDERS	☐	EATING DISORDER, LOSS OF APPETITE OR INCREASED APPETITE
☐	MOOD SWING, BIPOLAR, DEPRESSION, MANIA	☐	POOR SOCIAL SKILLS AND INTERACTIONS
☐	THOUGHT DISORDERS, PARANOID, SUSPICIOUS, DELUSIONAL	☐	SLOWED OR SLURRED SPEECH
☐	MEMORY LOSS, CONFUSION, DISORIENTATION	☐	INCREASED BODY MOVEMENTS
☐	APATHETIC, LISTLESS, FEARFUL, DEPENDENT	☐	LOW SELF ESTEEM, POOR MOTIVATION
☐	POOR PERSONAL HYGIENE	☐	LOSS OF INITIATIVE
☐	ANGRY, AGGRESSIVE, ARGUMENTATIVE, RESISTS SUPERVISION	☐	DESTRUCTIVE TO PROPERTY, HISTORY OF SETTING FIRES
☐	HALLUCINATIONS, HEARS VOICES	☐	SLEEP DISTURBANCE, DIFFICULTY FALLINGS ASLEEP, STAYING AWAKE
☐	TROUBLE CONCENTRATING, ORGANIZING, MAKING DECISIONS	☐	CHAIN SMOKES, UNSAFE SMOKER
☐	FATIGUE, LOW ENERGY LEVEL	☐	SUICIDAL THREATS OR BEHAVIOR
☐	EXHIBITS INAPPROPRIATE SEXUAL BEHAVIOR	☐	HISTORY OF VIOLENCE AND/OR CRIMINAL OFFENSE
☐	OTHER: _____		

HEARING CONCERNS:

VISION CONCERNS:

DIET REQUIREMENTS:

Significant Losses ***(may include death of a loved one, loss of driver's license, loss of occupation, etc. Please indicate when loss occurred.):***

SECTION XIV: GUARANTOR INFORMATION (Please attach a copy of last year's tax statement)

HAS ANYONE BEEN ASSIGNED AS LEGAL REPRESENTATIVE OF THE PROSPECT?

☐ **YES** ☐ **NO** If yes, complete the information below:

☐ **POWER OF ATTORNEY NAME:**	**DATE OF APPOINTMENT:**
☐ **LEGAL GUARDIAN**	**LEGAL GUARDIAN NAME:**
☐ **TEMPORARY** ☐ **PERMANENT**	
RESPONSIBLE PARTY FOR FINANCIAL MATTERS:	**ADDRESS (Street, City, State, Zip Code):**

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SECTION XV: FINANCIAL INFORMATION

INCOME:

	MONTHLY AMOUNT	NAME OF PAYEE	WHERE SENT
SOCIAL SECURITY	$		
VETERAN'S BENEFITS	$		
PENSIONS:			
COMPANY	$		
RAILIROAD	$		
GOVERNMENT	$		
REAL ESTATE	$		
TRUST FUND(S)	$		
TOTAL	$		

CASH ON HAND IN FINANCIAL INSTITUTIONS:

ACCOUNT	AMOUNT	JOINT ACCOUNT
RETIREMENT	$	☐ YES ☐ NO
CHECKING	$	☐ YES ☐ NO
SAVINGS	$	☐ YES ☐ NO
OTHER	$	☐ YES ☐ NO
TOTAL	$	

INVESTMENTS:

STOCKS	$
BONDS	$
NOTES	$
OTHER	$
TOTAL	$

SECTION XVI: INSURANCE

☐ LIFE INSURANCE (Cash Surrender Value):	LIFE INSURANCE (Face Value):	
☐ LONG TERM CARE INSURANCE (Benefit Allowed):	NAME OF INSURER:	POLICY NUMBER:

SECTION XVII: REAL ESTATE

	AMOUNT	FULLY OWNED	IF NO, AMOUNT OF EQUITY	JOINT OWNERSHIP
LAND	$	☐ YES ☐ NO	$	☐ YES ☐ NO
HOMESTEAD	$	☐ YES ☐ NO	$	☐ YES ☐ NO
OTHER	$	☐ YES ☐ NO	$	☐ YES ☐ NO

HAS ANY REAL ESTATE BEEN SOLD OR TRANSFERRED WITHIN THE LAST TWO (2) YEARS?

☐ YES ☐ NO **If yes, please complete the information below:**

PROPERTY ADRESS (Street, City, State, Zip Code):	COUNTY:
PROPERTY ADRESS (Street, City, State, Zip Code):	COUNTY:

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SECTION XVIII: ADVANCE DIRECTIVES		
DO NOT RESUSCITATE	LIVING WILL	POLST
☐ YES ☐ NO	☐ YES ☐ NO	☐ YES ☐ NO

SECTION XIX: FUNERAL ARRANGEMENTS	
ARE PRE-PAID FUNERAL ARRANGEMENTS MADE?	BURIAL ACCOUNT AMOUNT:
☐ YES ☐ NO	
FUNERAL HOME PREFERENCE NAME:	ADDRESS:

SECTION XX: DISPOSITION OF INQUIRY **FOR INTERNAL USE ONLY**

☐ ACCEPTED/CONTACT FOR PREADMISSION SCREENING

☐ REJECTED/CANCELLED REASON:

DISPOSITION MADE BY (PRINT NAME):	SIGNATURE:
TITLE	DATE:

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