APPLICATION FOR RESIDENCY & HEALTH HISTORY

Today's Date:______________________________ Referred to us by:__________________ ______________________ Completed by:_____________________________________ Relationship to Resident:___________________________

Room Preference Private Semi-Private Price Quoted___________ for Room #:_________________

Potential Move-in Date:____
A non-refundable $500 deposit can be given to hold the room for one week. This amount does NOT go towards the first month's rent. A community fee of $1000 is required upon move in.

Location Preference: (Check One) Tender Heart Westridge Village Robin House Casa del Norte

GENERAL RESIDENT INFORMATION:

Resident Name: ________________ ____ Gender: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Date of Birth:________________________ Age:________________Height:____________________Weight:________________

Resident's Current Location: ____
(Location where assessment is to be completed)

Next of Kin/Resident Representative Name:____

Contact #:____ E-mail:____

Is resident eligible for Veteran's Benefits? ☐ Yes ☐ No ☐ Unknown

Does resident have Long Term Care Insurance? ☐ Yes ☐ No

Is resident a Medicaid/Centennial Care Recipient? ☐ Yes ☐ No

If yes, Name of MCO and Member #:____

HEALTH INFORMATION

Primary Care Physician's Name:________________________________Phone #:________________________________

Other Physician's Name:_______________________________________Specialty_______________________________

Other Physician's Name:_______________________________________Specialty:_______________________________

HEALTH CARE SERVICES

Has the resident received any services from agencies such as home health or hospice in the last 6 months ?

If so, please list the name of the company:____

Reason:____Dates:_______________________________________

Allergies to Food and/or Medications:____

Describe any physical limitations the resident presently has:____

____

In order for us to ensure the resident will be an appropriate placement, please list any medical equipment / assistive devices currently used including, but not limited to, wheelchair, walker, hearing aids, dentures, hoyer lifts, geri chairs:
Other: ____

Describe any cognitive limitations the resident presently has: ____

____

List any illnesses, including mental or emotional, the resident presently has or has been treated for in the past two years:

____

Date of Last Hospitalization:______________________________Reason:_______________________________________

Has the resident been in a nursing home, assisted living, or any other type of long term care facility in the last year?

If so, where:____

What was the reason for leaving?____

Does the resident have a Power of Attorney, Trustee, or anyone else who handles his/her financial affairs? Yes No

If yes, name/relationship of responsible person:____

Approximately Length of Stay/Services Requested: ☐ 1-3 months ☐ 3-6 Months ☐6 Months +

Other:____

If less than six months, please explain: ____

Please use the space below to tell us what is important to you regarding the care of your loved one and what you are looking for in an assisted living community:

____

____

_____________________________________ _____________________________
Resident, Relative, or Representative Date

If you are interested in moving forward with admission to one of our communities, please complete and return this application to the location where you toured, or fax to 800-557-3574 or e-mail to mayers.apal@gmail.com. Upon receipt, we will contact you to set up the next steps.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

1. Authorization** I authorize ***Preferred Assisted Living, Inc.,*** (healthcare provider) to use and disclose the protected health information described below to ____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare for all past, present, and future periods.

3. Extent of Authorization

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until I revoke it.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____ _________________________________

Signature of Patient or Personal Representative Date

____

Printed Name of Patient or Personal
Representative and his/her relationship to patient

____ _________________________________

Signature of Witness Date

____

Printed Name of Witness and Facility Witness
Represents

PLEASE FAX REQUESTED RECORDS TO 800-656-0960 *OR*
E-MAIL TO LYNNE.BLAKE@GMAIL.COM