

YouvilleHouse  Youville Place
Assisted Living Residences

APPLICATION

Thank you for your interest in our Youville Assisted Living Residence, a member of Covenant Health Systems. Youville is a private, not-for-profit residence that welcomes and accepts people of all races, cultures and religions. Please complete this application form and return it to Youville.

All information will be kept confidential.

SECTION ONE GENERAL INFORMATION

Applicant's name

Social Security number

Permanent address

City

State

Zip Code

How long have you resided at this residence?

Rent

Own

Telephone numbers Home: ()

Cell: ()

Date of birth / /

Place of Birth

Marital status

Email

Current or past occupation

Religion

In case of emergency, please notify:

Name

Relationship

Address

City

State

Zip Code

Telephone day: ()

Telephone night: ()

Cell: ()

Email:

Will you bring an automobile to Youville? Yes

No

Automobile information:

Make

Model

License plate #

Color

How did you hear about Youville Assisted Living?

Reason for seeking assisted living residency:

SECTION TWO HEALTH CARE

Physician's name:

How long has she/he been your primary care physician?

Address City State Zip code

Telephone () Fax ()

Hospital affiliation City State

Are you receiving other medical, nursing or support services presently? Yes No

Please list agency or person and frequency per week:

Agency Frequency

Home Health Services Yes No

Homemaking Yes No

Hospice Yes No

Personal Care Services Yes No

Adult Day Program Yes No

Family Yes No

Other Yes No

Describe your current state of health:

Are you currently taking any medications? Yes No

Do you need assistance taking your medications? Yes No

List medications and frequency:

SECTION THREE MEDICAL INSURANCE INFORMATION

List your medical insurance(s):

Medicare Policy Type Policy #

Medicaid Policy Type Policy #

Medex Policy Type Policy # Other:

Do you have long term care insurance? Yes No

Company Policy #

Have you prepared advanced health care directives?

Health Care Proxy Yes No Name:

Power of Attorney Yes No Name:

Guardian Yes No Name:

Conservator Yes No Name:

Other Yes No Name:

SECTION FOUR HOUSING

With whom do you presently reside?

- alone with family assisted living community other
-

Specify any needs or concerns the staff should be aware of:

Describe any special adaptive devices that you may need in your apartment:

SECTION FIVE OTHER

Do you need assistance with any of the following?

- | | | |
|--------------------------------------|------------------------------|-----------------------------|
| Cooking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Housekeeping | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Laundry | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Understanding fire safety procedures | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Financial matters | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shopping | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Transportation | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bathing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Dressing | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Preparation for bed | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Transferring in and out of bed/chair | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Walking | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Climbing stairs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Taking medication | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Other | | |
-

Are you on a special diet? If yes, please describe:

Can you manage appropriate food selections? Yes No

Do you have any allergies? Yes No

Do you smoke? Yes No

Please describe your hobbies, interests, etc.

Completing the following section is optional. It would be helpful to us in fulfilling our responsibilities under Fair Housing laws, if you identify yourself by one of the following designations:

- White African American Asian American Indian Other
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SECTION SIX FINANCIAL INFORMATION

Please complete the following information. *This information will be kept in strictest confidence.*

MONTHLY INCOME

Social Security (Gross monthly benefit)	\$
Pension	\$
Other, please list	\$
	\$
Total monthly income	\$

Bank accounts	Average Balance
Bank	\$
Bank	\$

ADDITIONAL FINANCIAL RESOURCES

Assets	Approximate Capital Value	Monthly Income from Assets
Annuity	\$	\$
Stocks	\$	\$
Savings	\$	\$
Trust accounts	\$	\$
CDs	\$	\$
Bonds	\$	\$

Real estate in applicant’s name or joint ownership	Approximate Value
Location	\$
Location	\$

Long term care policies that cover assisted living services? Yes No

Company _____ Policy number _____

Any other source of income? Describe:

Any debts, mortgages or other financial obligations that would affect your income or assets?

As part of the application process you may be asked to submit the following:

1. Bank statements for the last three months
2. Last year’s tax return

The financial information included in this statement is true and is submitted in application for residency at Youville Assisted Living. I understand and agree that the foregoing application is not a contract or reservation for residence. Nothing contained herein is binding on either party until a Residency Agreement is signed by the parties hereto. I certify that the information which I have provided in this application is true and correct to the best of my knowledge and belief.

Signature of applicant _____ Date _____ / _____ / _____

A member of our staff will contact you shortly to schedule an appointment to meet with you.

You are encouraged to bring a family member or representative to any meeting at Youville.

Date received at Youville _____ / _____ / _____ Initials _____

