PREFERRED ASSISTED LIVING INC.

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 #:_____
(Upon move-in the amount due will be the pro-rated daily rate for the remainder of the current month; the next month in advance IF move-in date is after the 15th of the current month, and a $2000 deposit, $500 which covers the private move-in caregiver and is non-refundable, and the remainder is kept on the account to cover any days and/or invoices outstanding at the end of the contract. Any amount left of the $1500 will be refunded)

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.

Location Preference: (Circle One) Tender Heart Westridge Village Casa Bella

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 circle 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

_____ _____

PAL Representative Date

Faxed to Lynne and Matt on:_____

Application Approved and forwarded to RN for assessment on: _____