# Application for Residency

The Heritage
*A Community of* ThedaCare

This is a confidential application for residency. Completion of this application is not a guarantee of placement. The return of this completed document will place the applicant on the waiting list at our continuing care community. It will be used to assist in determining how to meet the medical, social and psychosocial needs of the potential resident.

Name: _____
Last First Middle initial

Spouse: _____
Last First Middle initial

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Birth date: _____ / _____ / _____ Spouse birth date: _____ / _____ / _____

Marital status (circle): ☐ married ☐ widowed ☐ divorced ☐ single

**Please provide the following information:**

Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dentist: _____ Phone: _____

Specialty physician: _____ Type: _____ Phone: _____

Specialty physician: _____ Type: _____ Phone: _____

Allergies (food and medications): _____

Pharmacy: _____ Phone: _____

Hospital preference: _____ Funeral preference: _____

Code status (circle): Do not resuscitate Full code

❑ Healthcare Power of Attorney ❑ Guardian ❑ Living Will

❑ Advanced Directive ❑ Financial Power of Attorney

Spouse physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Dentist: _____ Phone: _____

Specialty physician: _____ Type: _____ Phone: _____

Specialty physician: _____ Type: _____ Phone: _____

Allergies (food and medications): _____

Pharmacy: _____ Phone: _____

Hospital preference: _____ Funeral home: _____

Code status (circle): Do not resuscitate Full code

❑ Healthcare Power of Attorney ❑ Guardian ❑ Living Will

❑ Advanced Directive ❑ Financial Power of Attorney

**Emergency contact #1:**

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

**Additional contacts:**

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

**Responsible party (person responsible for paying the bill):**

Name: _____ Relationship: _____

Address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell phone: _____ Work phone: _____

**Please indicate your first and second apartment preferences at The Heritage.**

❑ One bedroom ❑ Two bedroom standard ❑ Two bedroom deluxe

❑ Two bedroom suite ❑ Studio (CBRF)

**Monthly financial information (this information will be kept strictly confidential):**

**Fixed monthly income:** Social Security: $ _____

Private pensions: $ _____

Other: $ _____

| **Assets:** | | **Liabilities:** | |
|---|---|---|---|
| Stocks and bonds: | $ _____ | Mortgages: | $ _____ |
| Available cash (savings and checking): | $ _____ | Personal loans: | $ _____ |
| Real estate (including your home): | $ _____ | Other obligations: | $ _____ |
| Total assets: | $ _____ | Net worth: | $ _____ |

**I declare that the information contained on this application is true and complete to the best of my knowledge. I understand that I will be asked to authorize a release of any medical information necessary to assist in making appropriate placement decisions prior to admission.**

_____ _____/_____/_____

**Signature of applicant or responsible party** **Date**

_____ _____/_____/_____

**Signature of second occupant** **Date**