



# Residency Application

*Please provide photo copies of both front and back sides of:*

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Social Security card       | <input type="checkbox"/> Medicare card                 | <input type="checkbox"/> Medical Assistance card    |
| <input type="checkbox"/> Prescription Drug card     | <input type="checkbox"/> Health Insurance card         | <input type="checkbox"/> Other medical/health cards |
| <input type="checkbox"/> Power of Attorney-Finances | <input type="checkbox"/> Power of Attorney-Health Care | <input type="checkbox"/> Photo ID                   |

**Personal Information:**

Name \_\_\_\_\_  
(Mr./ Mrs./ Miss)      Last                      First                      Middle                      Maiden

Home Address \_\_\_\_\_

Phone: Home \_\_\_\_\_ / \_\_\_\_\_      Cell \_\_\_\_\_ / \_\_\_\_\_

Rent \_\_\_\_\_ Own \_\_\_\_\_      County and State of legal residence \_\_\_\_\_

Currently residing at home address (Y/N) \_\_\_\_\_      If No, where \_\_\_\_\_

Have you ever lived in a retirement home or nursing home?    Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, where? \_\_\_\_\_      When? \_\_\_\_\_

Date of Birth \_\_\_\_\_      Birthplace \_\_\_\_\_      Current Age \_\_\_\_\_

Occupation(s) \_\_\_\_\_

U.S. Citizen?      Yes \_\_\_\_\_ No \_\_\_\_\_      Race \_\_\_\_\_

Are you a Veteran?    Yes \_\_\_\_\_ No \_\_\_\_\_      Are you a Veteran's dependent?    Yes \_\_\_\_\_ No \_\_\_\_\_

Religious affiliations \_\_\_\_\_

Mailing address \_\_\_\_\_

Preferred clergy \_\_\_\_\_      Phone \_\_\_\_\_ / \_\_\_\_\_

Marital status:      \_\_\_\_\_ Single      \_\_\_\_\_ Married      Marriage Date \_\_\_\_\_  
                                 \_\_\_\_\_ Widowed      \_\_\_\_\_ Divorced      \_\_\_\_\_ Separated

Spouse's name \_\_\_\_\_      Living? \_\_\_\_\_      If not, date of death \_\_\_\_\_

Mailing address if living \_\_\_\_\_

**Legal Representative(s) (please attach copy of legal documents)**

***Power of Attorney for Health Care?***

Yes\_\_\_\_\_ No\_\_\_\_\_ If Yes, Name\_\_\_\_\_

Mailing address\_\_\_\_\_

Phone: Home\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Work\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Cell\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

***Power of Attorney for Finances?***

Yes\_\_\_\_\_ No\_\_\_\_\_ If Yes, Name\_\_\_\_\_

Mailing address\_\_\_\_\_

Phone: Home\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Work\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Cell\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

***Guardian?***

Yes\_\_\_\_\_ No\_\_\_\_\_ If Yes, Name\_\_\_\_\_

Mailing address\_\_\_\_\_

Phone: Home\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Work\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Cell\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Person to receive business mail (individual responsible for financial matters)**

Name\_\_\_\_\_ Phone\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Mailing address\_\_\_\_\_

**Persons to contact in case of serious illness, injury, or death (list in priority order)**

1. ***Power of Attorney for Health Care( if listed above)***

2. ***Name***\_\_\_\_\_ ***Relationship***\_\_\_\_\_

Mailing address\_\_\_\_\_

Phone: Home\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Work\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Cell\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

3. ***Name***\_\_\_\_\_ ***Relationship***\_\_\_\_\_

Mailing address\_\_\_\_\_

Phone: Home\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Work\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Cell\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

4. ***Name***\_\_\_\_\_ ***Relationship***\_\_\_\_\_

Mailing address\_\_\_\_\_

Phone: Home\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Work\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Cell\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Medical Personnel**

*Physician* \_\_\_\_\_ Phone \_\_\_\_\_ / \_\_\_\_\_

Mailing address \_\_\_\_\_

*Dentist* \_\_\_\_\_ Phone \_\_\_\_\_ / \_\_\_\_\_

Mailing address \_\_\_\_\_

*Specialists* (list names) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Funeral Home** \_\_\_\_\_ Phone \_\_\_\_\_ / \_\_\_\_\_

Mailing address \_\_\_\_\_

Prepaid burial fund? Yes \_\_\_\_\_ No \_\_\_\_\_

**Admission Preferences**

*Type of accommodation desired:*

Independent Living

\_\_\_\_ Evergreen Village

\_\_\_\_ Evergreen Homes

\_\_\_\_ Manor Apartments

Assisted Living

\_\_\_\_ Garden Heights

\_\_\_\_ Garden Terrace

\_\_\_\_ Garden Place

\_\_\_\_ ShareHaven (dementia care)

Skilled Nursing

\_\_\_\_ Evergreen Health Center

*Desired date of admission* \_\_\_\_\_

*Person to contact to arrange admission*

Name \_\_\_\_\_ Phone \_\_\_\_\_ / \_\_\_\_\_

Mailing address \_\_\_\_\_

*Anticipated length of stay?* \_\_\_\_\_ Permanent \_\_\_\_\_ Temporary

**Insurance Information** (please provide copies of all applicable cards)

**Social Security Number** \_\_\_\_\_

**Medicare**

Medicare Number \_\_\_\_\_

Are you enrolled in a Medicare Replacement Plan (fee for service)? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, indicate plan below:

- |  |                                 |
|--|---------------------------------|
| _____ Advantra Freedom                   | _____ Humana (Gold or Standard) |
| _____ United Health                      | _____ Evercare                  |
| _____ Secure Horizons                    | _____ BCBS Smart Value          |
| _____ Network Platinum Plus (or Premium) | _____ Other _____               |

Policy Number \_\_\_\_\_

**Medical Assistance Number** (if applicable) \_\_\_\_\_

**Other Insurance**

Type	Company & Address	Policy Identification
Medicare Supplemental Insurance	Company Name	Group Number
	Address	Policy or Member Number
Prescription Drug Plan or Medicare Part D	Company Name	Group Number
	Address	Policy or Member Number
Private Health Insurance	Company Name	Group Number
	Address	Policy or Member Number
Long Term Care Insurance	Company Name	Group Number
	Address	Policy or Member Number

**Financial Information**

*Monthly Income*

Social Security \$ \_\_\_\_\_  
 Pension(s) \_\_\_\_\_  
 Annuities \_\_\_\_\_  
 Wages \_\_\_\_\_  
 Interest \_\_\_\_\_  
 Dividends \_\_\_\_\_  
 Rent \_\_\_\_\_  
 Other \_\_\_\_\_  
  
 Total \$ \_\_\_\_\_

*Assets*

Checking Accounts \$ \_\_\_\_\_  
 Savings Accounts \_\_\_\_\_  
 Stocks \_\_\_\_\_  
 Bonds \_\_\_\_\_  
 Personal Residence \_\_\_\_\_  
 Other Real Estate \_\_\_\_\_  
 Certificates of Deposit \_\_\_\_\_  
 Life Insurance (cash value) \_\_\_\_\_  
 Other \_\_\_\_\_  
  
 Total \$ \_\_\_\_\_

*Liabilities*

Home Mortgage \_\_\_\_\_  
 Credit Cards \_\_\_\_\_  
 Line of Credit \_\_\_\_\_  
 Co-signed debt \_\_\_\_\_  
 Other Debt \_\_\_\_\_  
  
 Total \$ \_\_\_\_\_

All information in this application is the truth to the best of my knowledge. Any misrepresentations could result in termination of the Residency Agreement.

Signed by \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
 (Identify relationship if not applicant)



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