Evergreen
Possibilities await.

Residency Application

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

___ Social Security card ___ Medicare card ___ Medical Assistance card
___ Prescription drug card ___ Health insurance card ___ Other medical/health cards
___ Power of Attorney-Finances ___ Power of Attorney-Health Care ___ Photo ID

Personal Information

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

Home address _____

Email address _____

Home phone _____ Cell phone _____

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) _____

United States 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: married ____ If currently married, date of marriage _____

single ____ widowed ____ divorced ____ separated ____

Spouse's name_____ Living?_____ If not, date of death_____

Mailing address if living _____

Legal Representatives (please attach copy of legal documents)

Power of Attorney for Health Care yes ____ no ____

If yes, name _____ Relationship _____

Mailing address_____

Email address _____

Phone: Home _____ Work _____ Cell _____

Power of Attorney for Finances yes ____ no ____

If yes, name _____ Relationship _____

Mailing address_____

Email address _____

Phone: Home _____ Work _____ Cell _____

Guardian yes ____ no ____

If yes, name _____ Relationship _____

Mailing address_____

Email address _____

Phone: Home _____ Work _____ Cell _____

Person to receive billing statements (individual responsible for financial matters, if other than self)

Name _____ Phone _____

Mailing address _____

Email address _____

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

1. Power of Attorney for Health Care (first, if listed above)
2. Name _____ Relationship_____

Mailing address _____

Email address _____

Phone: Home _____ Work _____ Cell _____

3. Name _____ Relationship_____

   Mailing address _____

   Email address _____

   Phone: Home _____ Work _____ Cell _____

4. Name _____ Relationship_____

   Mailing address _____

   Email address _____

   Phone: Home _____ Work _____ Cell _____

Medical Personnel

Physician _____ Phone _____

Email address _____

Mailing address _____

Dentist _____ Phone _____

Email address _____

Mailing address _____

Specialists (list names) _____

_____

_____

_____

Funeral Home _____ Phone _____

Email address _____

Mailing address _____

Prepaid burial fund? yes ____ no ____

Admission Preferences

Type of accommodation desired:

Independent Living	Assisted Living	Skilled Nursing
___ Evergreen Village	___ Garden Place - RCAC	___ Creekview long-term
___ Evergreen Homes	___ Garden Terrace - RCAC	___ Creekview short-term rehab
___ Manor Apartments	___ Garden Heights - CBRF	
___ Courtyard Apartments	___ Manor View - CBRF	
	___ ShareHaven - CBRF memory care	

Desired date of admission _____

Person to contact to arrange admission

Name _____ Phone _____

Mailing address _____

Anticipated length of stay? permanent ____ temporary ____

Social Security Number _____

Medicare Number _____

Medical Assistance Number (if applicable) _____

Insurance Information (please provide copies of all applicable cards)

Insurance Type	**Company Name & 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
Medicare Advantage Plan (fee for service)	**If yes, which company?** ___ United Health Medicare Complete ___ Network Platinum Plus or Premier ___ Humana Gold or Standard ___ Other _____	Group number
		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)	_____
Annuity distributions	_____
IRA distributions	_____
Wages	_____
Interest	_____
Dividends	_____
Rent	_____
Other income	_____
TOTAL	**$ _____**

ASSETS

Checking accounts	$ _____
Savings accounts	_____
Stocks	_____
Bonds	_____
Annuities	_____
IRAs	_____
Certificates of Deposit	_____
Life insurance (cash value)	_____
Personal residence	_____
Other real estate	_____
Other assets	_____
TOTAL	**$ _____**

LIABILITIES

Home mortgage	_____
Credit cards	_____
Line of credit	_____
Co-signed debt	_____
Other debt	_____
TOTAL	**$ _____**

I certify that the assets listed above will be available for use toward future living expenses at Evergreen.
Any misrepresentations could result in termination of the Residency Agreement.
All information in this application is the truth to the best of my knowledge.

Signature _____ Date _____

_____
(Identify relationship if not applicant)