THE SELFHELP HOME
A TRADITION OF CARING

Resident Application

Date_____

Applicant's Name _____

Gender of Applicant ☐ Male ☐ Female ☐ Other _____

Person Completing Application _____

Applicant Address _____

City / State / Zip _____

Phone Number (_____) _____ Date of Birth _____

Email Address _____ Social Security Number _____

Primary Insurance _____ ID Number _____

Do you have Secondary Insurance ☐ **Yes** ☐ **No**

If Yes, Name and ID Number _____

Please list any other Medical Insurance

If Yes, Name and ID Number _____

Do you have Long Term Care Insurance? ☐ **Yes** ☐ **No** Company Name _____

Contact _____ Phone _____

Are you a Veteran? ☐ **Yes** ☐ **No** If yes, list the Unit _____

Are you a Holocaust Survivor ☐ **Yes** ☐ **No**

How did you or your family hear about Selfhelp Home?_____

_____

Are you a member of a Religious Congregation? ☐ **Yes** ☐ **No** Synagogue Name _____

Your Personal History

Marital status? ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Where were you born? City _____ Country _____

Where did you live before you immigrated (if applicable)?

City _____ Country _____

When did you arrive in the U.S.? _____

What was your occupation? _____

Current Residence

Are you currently living alone? ☐ **Yes** ☐ **No**

If no, who are you living with? ☐ Independent ☐ Spouse ☐ Relatives ☐ Other (Specify) _____

Do you ☐ Own or ☐ Rent?

Are you living in ☐ An Apartment ☐ Own Home

☐ Retirement / Nursing Facility (Specify) _____

Emergency Contact Person

This person is also my ☐ Power of Attorney for Healthcare ☐ Power of Attorney for Property ☐ Legal Guardian

1.) Name _____ Relationship _____

Cell Phone _____ Other Phone _____

Home Address _____

City / State _____ Zip Code _____

Email Address _____

This person is also my ☐ Power of Attorney for Healthcare ☐ Power of Attorney for Property ☐ Legal Guardian

2.) Name _____ Relationship _____

Cell Phone _____ Other Phone _____

Home Address _____

City / State _____ Zip Code _____

Email Address _____

This person is also my ☐ Power of Attorney for Healthcare ☐ Power of Attorney for Property ☐ Legal Guardian

3.) Name _____ Relationship _____

Cell Phone _____ Other Phone _____

Home Address _____

City / State _____ Zip Code _____

Email Address _____

Do you have a Living Will? ☐ **Yes** ☐ **No**

Preferred Accommodations at Selfhelp

Choice of residence? ☐ Independent Living ☐ Assisted Living ☐ Skilled Nursing / Long-term Care

If Independent / Assisted Living, choice of accommodations

☐ Studio Residence ☐ One Bedroom Residence

Choice of meal service? ☐ Three Meals Daily ☐ Two Meals Daily

When would you like to move to Selfhelp? _____

Do you have a friend or relative currently residing at Selfhelp? ☐ **Yes** ☐ **No**

If Yes, Name _____ Relationship _____

Has any member of your family been a resident of Selfhelp? ☐ **Yes** ☐ **No**

If Yes, Name _____ Relationship _____

Medical Information

Physician's Name _____

Address _____

Phone Number _____ Fax Number _____

Do you have any other consulting physicians? ☐ **Yes** ☐ **No**

If yes, please list physician(s) name(s) below

_____ _____

_____ _____

_____ _____

Have you been hospitalized within the last year? ☐ **Yes** ☐ **No**

If yes, please list what hospital, date of hospitalization and reason _____

_____

_____

_____

Are you currently taking any medication? ☐ **Yes** ☐ **No**

If yes, please list medication, frequency, and dosage _____

_____

_____

_____

Do you have a dentist? ☐ **Yes** ☐ **No** If Yes, Name _____

Do you have any dietary restrictions? ☐ **Yes** ☐ **No** If yes, what are they? _____

Are you currently using any assistive devices? ☐ **Yes** ☐ **No** If yes, please check below

☐ Walker ☐ Wheelchair ☐ Power Mobility Device ☐ Glasses ☐ Cane ☐ Hearing Aid

☐ Other _____

Have you received the COVID-19 Vaccine? ☐ **Yes** ☐ **No** Date of last vaccination _____

Have you received a flu vaccination this year? ☐ **Yes** ☐ **No**

Have you received a pneumonia vaccination this year? ☐ **Yes** ☐ **No**

Have you received a TB test? ☐ **Yes** ☐ **No** If so, when? _____

Other pertinent medical information:

_____

_____

_____

(over)

Annual Income

Best Estimate

Please provide copies of supporting documentation for the following:

Pension Income

Social Security $_____

Retirement Pension, Insurance $_____

Other Pension (IRA, 401(k), etc.) $_____

Work Income … Employment, Business, Professional $_____

Dividends and Interest $_____

Other Income (Specify)_____ $_____

Support from Relatives $_____

Name _____

Relationship _____

Total **$** _____

Financial Resources

Please provide copies of supporting documentation for the following:

Cash in CDs, Money Market, Checking and Savings Accounts $_____

Estimated Value of Residential or Other Real Estate

Property (Less Mortgages) $_____

Investments in Mutual Funds, Stocks, Bonds, etc. $_____

Other (Specify) _____ $_____

Total **$** _____

Signature _____ Date _____

FOR OFFICE USE ONLY

Received by _____ Date _____

Approved by _____ Date _____

Comments _____

_____

_____

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