Address						
City	State		Zip			
Move in Date	Apartment _		Phone			
	EMERGENCY INFOR	RMATION				
In care of emergency notify:						
Name	Relationship)				
Address	City	State	Zip			
Home No	Work No.	Cell No)			
N.	D.L.					
Name	•					
Address	City	State	Zip			
Home No.	Work Noe list any additional contacts)			
Medicare#Supplemental Insurance						
Long Term Care Insurance Co	Does i	t cover Assisted Livi	ing?			
Policy#	Elimir	nation Period				
Please list the names of your appointed	persons that you would like	us to notify if need	ed:			
Power of Attorney	Phone	Phone				
Health Care Representative	Phone	Phone				
Trust Officer	Phone					
Trust Silicer						
Do you have a Living Will?Please provide copies of: Sociation		Health Care Repres	entative/Medicare Card			
Do you have a Living Will?Please provide copies of: Sociation	al Security Card/Living Will/ er of Attorney/Supplemental	Health Care Repres	entative/Medicare Card			



RESIDENCY APPLICATION



The Admission Review Committee Holds all information in confidence.

TO BE COMPLETED BY HOLIDAY VILLAGE					
I, Date	_ Studio	_ 1BR	_ 2 BR		
F. Info					

TO BE COMPLETED BY RESIDENT

Full Name	2:				Prefers to be	called	l:			
Address:_										
Telephone	:				Social Securi	ty Nu	mber:			
Date of Bir	rth: Month			_Day	Ye	ear				
Place of Bi	rth: City				State (County	y)				
Marital Sta	atus: Married	Spot	use's Name				Anniv	versary Dat	e	
Veteran	Branch	_Divorced	Single	Widowed_	Smoker:	Yes_	No	Pet(s)	Yes	No
			FAMILY	//FRIEND	INFORMA	ATIC	ON			
Name	Rela	ationship	A	ddress	City		State	Tel. N	o.	Cell No

(If additional space is needed please attach a separate sheet)

FINANCIAL DATA

The following information is requested in order that Holiday Village has assurance that your financial resources will be adequate to fulfill your need as a resident of the Village. The information supplied is strictly confidential.

What is the approximate value of	you private financial resources? \$				
What is you approximate monthly income? \$Social Security? \$					
Do you own real estate? Yes	No Cash Value				
Can your assets and/or income b	e used to pay for carte and service	es received? YesNo			
If no, explain					
If someone other than you admin	isters your finances and/or obliga	ations, please list this person's name, address and			
telephone number:					
Is this person: Guardian	Trust Officer	Attorney			
Relative	Other				
	PERSONAL	DATA			
Are you retired	Semi-Retired	Employed			
Past or Present Profession, Trade,	Occupation				
What are your Hobbies/Avocation	ons?				
Where are you living now?					
Of what church are you a member	r?				
When do you plan to move into the Village? Undecided					
Do you plan to bring your car?	esNoUndecided				
If yes, color and make of carLicense Plate#					
Do you want the use of a carport	(monthly rental plan)? Yes	No Undecided			
Would you like to receive the nev	vspaper? Yes No Dai	y Only Sunday Only Daily & Sunday			
	ence in Holiday Village of my ov ull and complete to the best of m	on free will and accord. I declare the answers to the y knowledge.			
Date	Signature				



HEALTH HISTORY

7		77			
Physician's Name					
Eye Doctor					
Podiatrist	Address:	Phone:			
Dentist	Address:	Phone:			
Are you now receiving treatment for any of the for Heart Condition	Cancer Diabetes Stroke Glaucoma Disease Fractures bove Yes or are you a DNR	_			
What is your hospital preference?	Ambulance Service?				
What is your funeral home preference?	Are plans prearranged?				
Do you require a special diet? YesNo					
Are you ambulatory and capable of independent	•				
Do you use a cane?Other	(Explain)				
List the medications you are now using (Please in Medications	clude those medications you take only a Strength/Dosage	ns needed) Time of day taken			
If you take part in our medication reminder service					
Place in apartment where organizer will be stored					
Day of the week the organizer be refilled					
Who will fill organizer?					
Signature of resident or party responsible for fillir	ng organizer				

