Lake Michigan SENIOR LIVING

License # AS530393662

NEW RESIDENT APPLICATION

Residents Name:

ADMISSION/DISCHARGE INFORMATION

Date of Admision:_____County:_____

Admitted from: Own home ☐ Hospital ☐ NH ☐ OMH ☐ Other (specify):_____

Address Admitted from (Street, City, State, ZIP_____

Discharge Date:_____ Discharge to: ☐Own home ☐Hospital ☐ NH ☐ OMH

☐ Other (Specify):_____

Address Discharged to (Street, City,State,Zip):_____

Reason for Discharge:_____

_____

SECTION 1: PERSONAL DATA

Date of Birth:___/___/___ Gender: ☐ M ☐ F Status: ☐Married ☐ Single ☐Divorced ☐Widowed ☐ Partner

NOTIFY IN CASE OF EMERGENCY

Name:_____Address:_____City:_____State:_____Zip_____

Relationship:_____

Home:_____ Work:_____

Cell:_____ Other:_____

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SECTION 1 PERSANAL DATA cont.

ATTENDING PHYSICIAN

Name:_____

Address:_____City:_____

State:_____Zip:_____

Phone:_____Fax:_____

OTHER HEALTH CARE PROVIDERS

Name:_____

Specialty:_____

Phone:_____Fax:_____

Address:_____City:_____

State:_____Zip:_____

Name:_____

Specialty:_____

Phone:_____Fax:_____

Address:_____City:_____

State:_____Zip:_____

Name:_____

Specialty:_____

Phone:_____Fax:_____

Address:_____City:_____

State:_____Zip:_____

OTHER HEALTH CARE PROVIDERS

Name:_____

Specialty:_____

Phone:_____Fax:_____

Address:_____City:_____

State:_____Zip:_____

Name:_____

Specialty:_____

Phone:_____Fax:_____

Address:_____City:_____

State:_____Zip:_____

Name:_____

Specialty:_____

Phone:_____Fax:_____

Address:_____City:_____

State:_____Zip:_____

AREA HOSPITAL/CLINIC OF CHOICE

Name:_____Address:_____

Additional Information:_____

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SECTION 1 PERSONAL DATA cont.:

Residents Name:_____

HEALTH INSURANCE

Insurer:_____

Id#:_____

Medicaid #:_____

Medicare #:_____

Prescription Drug Plan:_____

Plan ID#:_____

Other Health Care Coverage:_____

_____

PHARMACY

Pharmacy (ies)_____

_____

Phone:_____Phone:_____

Address (es)_____

_____

City:_____State:_____Zip:_____

City:_____State:_____Zip:_____

SECTION 2: PERSONAL BACKGROUND

Wishes to be addressed as:_____

Address (if different from ALR):_____

Residents Representative:_____Phone/ Home:_____

Relationship: _____ Cell:_____

Address:_____ Work:_____

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SECTION 2: PERSONAL BACKGROUND cont.

Residents Representative:_____Phone/ Home:_____

Relationship: _____ Cell:_____

Address:_____ Work:_____

Significant Other:_____Phone/ Home:_____

Relationship: _____ Cell:_____

Address:_____ Work:_____

Significant Other:_____Phone/ Home:_____

Relationship: _____ Cell:_____

Address:_____ Work:_____

Residential Background (born/raised, lived most of life):_____

_____

Occupational/Educational Backgroud:_____

_____

Religious Affiliation (if any):_____Place of Worship:_____Phone:_____

Health Care Proxy: ☐ Yes ☐ No (Name):_____ DNR: ☐ Yes ☐ No

Power of Attorney: ☐ Yes ☐ No (Name):_____Living Will: ☐ Yes ☐ No

Burial Instructions:_____

_____

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SECTION 3 PERSONAL FINANCIAL INFORMATION

I. INCOME: (Please write YES or NO in every space provided below. Fill in monthly amounts as applicable)

Do You Receive:

YES or NO	Income Source	Amount/Month
_____	**Social Security**	$_____
_____	**VA Pension**	$_____
_____	**Retirement/Pension**	$_____
_____	**Alimony**	$_____
_____	**SSI**	$_____
_____	**Rental Property**	$_____
_____	**Other**	$_____

Please list any other sources of income:_____

Total Monthly Income: $_____

II. ASSETS: (Please write YES or NO in every space provided below. List amount of asset where applicable)

YES or NO	Income Source	Amount/Month
_____	**Checking Account(s)**	$_____
_____	**Savings Account(s)**	$_____
_____	**CD's**	$_____

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_____	**Stocks**	**$**_____
_____	**Bonds**	**$**_____
_____	**IRA's**	**$**_____
_____	**Property**	**$**_____
_____	**Money Market**	**$**_____
_____	**Other**	**$**_____

Please list any other assets:_____

Life Insurance Cash Value **$**_____ **or** ☐ **N/A**

TOTAL CURRENT ASSETS: **$**_____

III. LIABILITIES:

YES or NO	Liability	Monthly Payment	Total Owed
_____	**Bank Loan**	**$**_____	**$**_____
_____	**Taxes Due**	**$**_____	**$**_____
_____	**Mortgage**	**$**_____	_____**Value**_____
_____	**Health Insurance**	**$**_____	**N/A**
_____	**Prescriptions**	**$**_____	**N/A**
_____	**Phone**	**$**_____	**N/A**
_____	**Cable**	**$**_____	**N/A**
_____	**Auto Loan**	**$**_____	_____**Value**_____

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_____	**Auto Insurance**	**$_____**	**$_____**
_____	**Other**	**$_____**	**$_____**

TOTAL LIABILITIES: **Monthly:** **$_____** **Total: $_____**

IV. PERSONAL NET WORTH (Total Assets minus Total Liabilities): **Total: $_____**

Please submit proof of income source and assets with this application.

_____ _____

Resident Signature Resident Representative Signature

_____

Lake Michigan Senior Living LLC Signature

Dated this _____day of _____20_____