	ANTONINE VILLAGE Administration Form	Code: ADM-FR-5	Page 1 of 4
	Resident Application	Approval date: 12/01/2014	Revision date: 10/22/2016

Applicant Information		
Are you applying for □ **Suite** □ **Assisted Living (AL)** □ **Memory Care (MC)**		
Last Name:	Middle:	First:
Date of birth: / /	Place of birth:	Gender: ☐ F ☐ M
Current address:		Phone: ( )
City:	State:	ZIP Code:
Marital Status: ☐ S ☐ M ☐ W ☐ Religious ☐ Priest		Veteran: ☐ Yes ☐ No
Name of Spouse		Phone: ( )
Address of Spouse		Cell Phone: ( )
City:	Zip Code:	Social Security #:
Medicaid:	Medicare:	Insurance
Names of children and/or interested persons		
Responsible Party:		
Relationship:		E-mail:
Phone: ( )	Cell phone: ( )	Fax:
Address		
City:	State:	ZIP Code:
Name of Emergency Contact #1:		
Relationship:		E-mail:
Phone: ( )	Cell phone: ( )	Fax:
Address		
City:	State:	ZIP Code:
Name of Contact # 2:		
Relationship:		E-mail:
Phone: ( )	Cell phone: ( )	Fax:
Address		
City:	State:	ZIP Code:
Name of Contact # 3:		Relationship:
Home Phone: ( )	Work Phone: ( )	Cell phone: ( )
Address		E-mail:
City:	State:	ZIP Code:

Does the applicant have a:	
Power of attorney for Health Care? ☐ Yes ☐ No	Name: Phone: ( )
Power of attorney for financial needs? ☐ Yes ☐ No	Name: Phone: ( )
Living Will? ☐ Yes ☐ No	Name: Phone: ( )
Court Appointed Guardian? ☐ Yes ☐ No	Name: Phone: ( )

Physician		
Present Attending Physician:		
Address:		
City:	State:	ZIP Code:
Phone: ( )	E-mail:	Fax:
Will this physician continue to care for the resident? ☐ Yes ☐No		
If not, can arrangements be made by the nursing staff for the services of one of the physicians at the Antonine Village? ☐ Yes ☐ No		
Hospital Preferred:		
Pharmacy used in community:		

Reason for applying to Antonine Village:

_____

_____

_____

How did you hear about Antonine Village?

☐ Friend or relative ☐ Sign ☐ TV ☐ Radio ☐ Newspaper ad or articles

☐ Other: _____

Activities for daily living:

Has he/she been diagnosed with Dementia/Alzheimer's Disease by a physician? □ Yes □ No

AMBULATION
☐ Walks alone ☐ Transfers alone ☐ Uses walker ☐ Uses cane ☐ Independent in wheelchair
Other: _____

EATING ☐ Feeds self ☐ Needs assistance Adaptive equipment needed: _____

HEARING ☐ Adequate ☐ Adequate with aid ☐ Poor ☐ Deaf

VISION ☐ Adequate ☐ Adequate with glasses ☐ Poor ☐ Blind

COMMUNICATION ☐ Normal speech ☐ Foreign language/accent: _____
☐ Communication deficit: _____

INTERACTION WITH OTHERS
☐ Friendly ☐ Anxious ☐ Quiet ☐ Other: _____

Do you understand and agree to the following provisions:		
1. Applicants must be capable of maintaining relative independence in their daily living with only limited assistance needed with personal care. Except for Memory Care Unit.	Yes	No
2. The resident's medications would be purchased at a pharmacy utilized by Antonine Village and paid for by the resident or insurance.	Yes	No
3. Payment must be made upon receiving the statement of charges which will be sent the first week of the month.	Yes	No
4. Charges may be adjusted at times according to the care required by the resident and/or other necessary reasons.	Yes	No
5. Residence at Antonine Village is subject to Assisted Living licensure regulations and requirements of the State of Ohio and may be revised at times.	Yes	No
6. Payment for one week will be charged if a resident leaves without giving at least one week notice.	Yes	No
7. Antonine Village will give a 30 day notice if a resident is asked to leave.	Yes	No
8. Residents will move into a health care facility of their choice, if in the judgment of their physician, their needs can no longer be met in the Antonine Village.	Yes	No

I HEREBY APPLY FOR ADMISSION as a resident and agree to the above mentioned terms.

I affirm that the information contained in this application is correct to the best of my knowledge and is submitted as part of my application for residency. I understand that additional information may be requested in the future. I agree to notify the administrative office in writing of any significant changes in the information contained herein.

I hereby authorize any physician or health treatment facility to release medical information that is requested for purposes of evaluating my application for residency.

I am aware that information submitted in this application process will be held in strict confidence. Upon approval for residency, all data will become part of my permanent and confidential record.

Applicant's Name _____

Responsible party Signature _____ Date _____