



# HEARTHSTONE RETIREMENT HOME

## I. GENERAL

Applicant's Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Permanent Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Present Address (if different): \_\_\_\_\_ Zip: \_\_\_\_\_

How long at present address? \_\_\_\_\_ Birth Place: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Current or former occupation: \_\_\_\_\_ Veteran? Yes: \_\_\_ No: \_\_\_

Sex: Male \_\_\_ Female: \_\_\_ Religion: \_\_\_\_\_

I am: Married \_\_\_ Widowed \_\_\_ Separated \_\_\_ Divorced \_\_\_ Single \_\_\_

Name of spouse: \_\_\_\_\_ Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Date & place of marriage: \_\_\_\_\_

If deceased, date of death: \_\_\_\_\_

How did you learn about our facility? \_\_\_\_\_

Person to contact in case of an emergency, serious illness or accident:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_



**II. LIVING ACCOMMODATIONS**

Please describe your present living accommodations: \_\_\_\_\_

Please describe any special needs or concerns of which Hearthstone's staff should be aware: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you currently rely on a relative, friend or home health aide to live with and/or assist you?

Yes: \_\_\_ No: \_\_\_ Who? \_\_\_\_\_ Why? \_\_\_\_\_

Do you anticipate the need for either part-time or 24-hour personal care/assistance? Yes: \_\_\_ No: \_\_\_

Have you ever resided in another independent living, assisted living and/or nursing facility?

Yes: \_\_\_ No: \_\_\_ Name of facility: \_\_\_\_\_

Periods of stay: From: \_\_\_\_\_ To: \_\_\_\_\_

Why did you leave that facility? \_\_\_\_\_

\_\_\_\_\_

**III. LEVEL OF DAILY ACTIVITY**

	Good	Fair	Poor		Good	Fair	Poor
Housekeeping	___	___	___	Shopping	___	___	___
Transportation	___	___	___	Laundry	___	___	___
Taking Medication	___	___	___	Fire Awareness	___	___	___
Walking	___	___	___	Budgeting	___	___	___

Personal Strengths & Interests: \_\_\_\_\_

\_\_\_\_\_



**IV. MEDICAL**

Physician's Name: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

How would you describe your current state of health? \_\_\_\_\_

How often do you presently see a physician? \_\_\_\_\_

Are you on medication(s) at this present time? Yes: \_\_\_ No: \_\_\_

If so, for what condition(s)? \_\_\_\_\_

Do you require assistance to administer medication? Yes: \_\_\_ No: \_\_\_

Do you smoke/drink alcohol? Yes: \_\_\_ No: \_\_\_ Do you have difficulty with stairs? Yes: \_\_\_ No: \_\_\_

Do you use a walker? Yes: \_\_\_ No: \_\_\_ Do you use a cane? Yes: \_\_\_ No: \_\_\_

Do you prepare your own meals? Yes: \_\_\_ No: \_\_\_ Are you on a special diet? Yes: \_\_\_ No: \_\_\_

History of Hospitalization, Institutionalization and/or Treatment for Psychiatric/Mental Diagnosis:

Date (s): \_\_\_\_\_

Where Treated: \_\_\_\_\_

Reason for Admission: \_\_\_\_\_

I am willing to provide any additional medical information as the Board of Directors/Administrator deems necessary to determine in the facilities of Hearthstone Retirement Home are adequate for me. I understand that Hearthstone Retirement Home is an independent retirement home and not a health care facility. Therefore, if I should ever need temporary or private personal care, I agree to pay the expenses of a special attendant or I agree to be removed to a hospital or like health care facility. In the event of serious illness, accident or a determination by the Board of Directors that my transfer to a hospital or like health care facility is necessary and advisable, I agree to assume responsibility for making the necessary arrangements. I understand that in the event of an unexpected medical event, the employees of Hearthstone Retirement Home will call 911, the Emergency Medical System.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_



**V. MEDICAL INSURANCE INFORMATION**

Do you have medical insurance? Yes:  No:  Medicare Number: \_\_\_\_\_

Long Term Care Insurance Number: \_\_\_\_\_ Name: \_\_\_\_\_

Other Health Insurance Number: \_\_\_\_\_ Name: \_\_\_\_\_

Life Insurance Name: \_\_\_\_\_ Beneficiary: \_\_\_\_\_

Approximate Value: \_\_\_\_\_ Face Value: \_\_\_\_\_

**VI. DRIVING**

Do you have a current, valid driver's license? Yes:  No:

Are you presently operating a vehicle? Yes:  No:

Do you plan on having an automobile at our facility? Yes:  No:



**VII. LEGAL REPRESENTATIVES**

Does anyone handle your financial affairs? Yes: \_\_\_\_ No: \_\_\_\_

If yes, who?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have a POA for healthcare? Yes: \_\_\_\_ No: \_\_\_\_

If yes, who?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

Do you have legal guardianship? Yes: \_\_\_\_ No: \_\_\_\_

If yes, who?

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_

**VIII. FUNERAL**

Do you have arrangements for interment? Yes: \_\_\_\_ No: \_\_\_\_

Name of Funeral Home: \_\_\_\_\_

Person responsible for the arrangement & finances:

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Zip: \_\_\_\_\_



**IX. FINANCIAL**

<b>Assets</b>	<b>Cash/Market Value</b>
Bank Accounts:	
Checking:	\$ _____
Savings:	\$ _____
Name of Company: _____	Address: _____
_____	Account Number: _____
Checking:	\$ _____
Savings:	\$ _____
Name of Company: _____	Address: _____
_____	Account Number: _____
Certificates of Deposit:	\$ _____
Stocks & Bonds:	\$ _____
401 (k)/IRA:	\$ _____
Name of Company: _____	Address: _____
_____	Account Number: _____
Life Insurance Policies:	\$ _____
Name of Company: _____	Address: _____
_____	Account Number: _____
Name of Company: _____	Address: _____
_____	Account Number: _____





**Asset Transfers**

Have any of your assets, either solely or jointly owned, been transferred, sold, or given as a gift: trust, annuities, life, estate, mortgages or otherwise to others in the last five (5) years? Assets include real estate, personal property, or cash in excess of \$ 1,000.00

Yes: \_\_\_\_ No: \_\_\_\_ If yes, complete the following:

Item Transferred: \_\_\_\_\_

Approximate Value: \_\_\_\_\_

To Whom: \_\_\_\_\_

Date of Transfer: \_\_\_\_\_

Item Transferred: \_\_\_\_\_

Approximate Value: \_\_\_\_\_

To Whom: \_\_\_\_\_

Date of Transfer: \_\_\_\_\_

**Liabilities**

**Amount Owed**

Home Mortgage \$ \_\_\_\_\_

Other Loans \$ \_\_\_\_\_

**TOTAL LIABILITIES:** \$ \_\_\_\_\_



Please describe the nature of your financial resources:

Employment Income: \$ \_\_\_\_\_  
Pension Income: \$ \_\_\_\_\_  
Family Assistance: \$ \_\_\_\_\_  
Social Security Income: \$ \_\_\_\_\_  
Interest Income: \$ \_\_\_\_\_  
Other: \$ \_\_\_\_\_  
Rental Income: \$ \_\_\_\_\_  
**TOATL FINANCIL RESOURCES:** \$ \_\_\_\_\_

**Declarations**

Are there any outstanding judgments against you? Yes: \_\_\_\_ No: \_\_\_\_

Have you been declared bankrupt within the past 7 years? Yes: \_\_\_\_ No: \_\_\_\_