Preliminary Application

Thank you for your interest in **Summerhill Assisted Living**. If you wish to be considered for residency, please complete this application and return it to us at the address at the bottom of this page. If a couple is applying please make a separate application for each person.

General

Applicant's Name: _____ Social Security: _____

Permanent Address: _____

How Long at This Address? _____ Rent or Own? _____ Telephone: _____ Cell: _____

Birth Date: _____ Birth Place: _____

Marital Status: _____ Current/Former Occupation: _____

Do You Own a Car? ☐ Yes ☐ No If Yes, Make and Year: _____

If You Own a Car, Would You Bring it to Summerhill? ☐ Yes ☐ No ☐ Not Sure

It would be helpful to us in carrying out our responsibilities under the Fair Housing Laws if you would identify yourself by one of the following designations. (Optional)

☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Other _____

Family Contact Name: _____ Telephone: _____ Cell: _____

Address: _____ Email: _____

Do You Have a Living Will? ☐ Yes ☐ No Who is Listed to Act in Your Behalf?

Name: _____ Telephone: _____ Cell: _____

Address: _____ Email: _____

Do You Have a Durable Power of Attorney for Healthcare? ☐ Yes ☐ No Who is Listed to Act in Your Behalf?

Name: _____ Telephone: _____ Cell: _____

Address: _____ Email: _____

Do You Have a Durable Power of Attorney for Finance? ☐ Yes ☐ No Who is Listed to Act in Your Behalf?

Name: _____ Telephone: _____ Cell: _____

Address: _____ Email: _____

Are You a Veteran? ☐ Yes ☐ No Are You a Spouse of a Veteran? ☐ Yes ☐ No

Is There Any Special Support/Assistance You Will Need If You Come to Summerhill?

_____

_____

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Medical

How Would You Describe Your Present State of Health? _____

_____

What Is Your Physician's Name: _____ Telephone: _____

Address: _____

Hospital Affiliation: _____

How Often Do You See Your Doctor? _____ Date of Last Visit: _____

Are You Taking Any Medications at the Present Time? ☐ Yes ☐ No

If Yes, Please List: _____

_____

_____

Name of pharmacy you currently use: _____

Phone: _____ Fax (if known): _____

Do You Require Assistance To Administer Your Medication? ☐ Yes ☐ No

Do You Prepare Your Own Meals? ☐ Yes ☐ No

If No, Who Prepares Them for You? _____

Are You on a Special Diet? ☐ Yes ☐ No If Yes, Please Explain: _____

_____

How Much Walking Do You Do Each Day? _____

Do You Have Difficulty With Stairs? ☐ Yes ☐ No

Do You Use a: ☐ Walker ☐ Cane ☐ Wheel Chair ☐ Other _____

Do You Have Medical Insurance? ☐ Yes ☐ No If So, Please List…

Company: _____ Policy/ID #: _____

Company: _____ Policy/ID #: _____

Do You Have Long-Term Care Insurance? ☐ Yes ☐ No If So, Please List…

Company: _____ Policy/ID #: _____

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Evaluating Your Needs

It would be helpful to us in evaluating your needs if you would rate your skills in the following areas. (Check the appropriate block.)

Task	Independent	Need Assistance	Complete Assistance	Comments
Cooking	Yes ☐	Yes ☐	Yes ☐	_____
Housekeeping	Yes ☐	Yes ☐	Yes ☐	_____
Laundry	Yes ☐	Yes ☐	Yes ☐	_____
Fire Awareness	Yes ☐	Yes ☐	Yes ☐	_____
Budgeting/Check Writing	Yes ☐	Yes ☐	Yes ☐	_____
Shopping	Yes ☐	Yes ☐	Yes ☐	_____
Transportation	Yes ☐	Yes ☐	Yes ☐	_____
Personal Hygiene	Yes ☐	Yes ☐	Yes ☐	_____
Dressing	Yes ☐	Yes ☐	Yes ☐	_____
Bathing	Yes ☐	Yes ☐	Yes ☐	_____
Walking	Yes ☐	Yes ☐	Yes ☐	_____
Taking Medications	Yes ☐	Yes ☐	Yes ☐	_____
Toileting	Yes ☐	Yes ☐	Yes ☐	_____
Conversing With Others	Yes ☐	Yes ☐	Yes ☐	_____

What Are Your Personal Strengths and Interests? _____

_____

_____

_____

Do You Like To Participate in Group Activities Such as Trips to Local Attractions, Attending Movie or Theater Performances, Group Exercise Classes, Etc. ? ☐ Yes ☐ No

How Do You Like To Spend Your Time Each Day?_____

_____

_____

_____

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Financial

Please describe the nature of your financial resources.

Assets

Savings Account(s) Amount	$ _____
Checking Account(s) Amount	$ _____
Investments, List and Give Amounts:	
_____	$ _____
_____	$ _____
_____	$ _____

Income

Employment	$ _____	Per Month
Social Security Payments	$ _____	Per Month
SSI Payments	$ _____	Per Month
Pension Payments	$ _____	Per Month
Interest/Dividend Payments	$ _____	Per Month
Life Insurance Payments	$ _____	Per Month
Support From Family	$ _____	Per Month
Rental Income Received	$ _____	Per Month
Other: _____	$ _____	Per Month
Total Income from All Sources:	**$ _____**	**Per Month**

Expenses

Insurance Premiums	$ _____	Per Month
Other, List and Give Amounts:		
_____	$ _____	Per Month
_____	$ _____	Per Month
_____	$ _____	Per Month
Total Expenses:	**$ _____**	**Per Month**

Financial Consideration to be aware of for incoming residents:

A $500 Non-Refundable administrative fee is due with the presentation of this application. Upon selecting a suite, a service deposit (equivalent to one month's rent) is due. This is held in an interest bearing escrow account.

I understand and agree that the foregoing application is not a contract or reservation for residency. Nothing contained herein is binding on either party until a Resident Admission Contract has been signed by the parties hereto.

I certify that the information which I have provided in this application is true and correct to the best of my knowledge and belief.

_____	_____
Date	Signature of Applicant
_____	_____
Date	Signature of Personal Representative - POA