Norse Home

Retirement & Assisted Living Community

Application for Residency

CONFIDENTIAL

Name of Applicant: _____

Date of application: _____

Office Use:

Received: _____

Approved by: _____ **Date:** _____

7/2011

GENERAL INFORMATION

Name: _____
Last *First* *Middle*

Address: _____
Street *City* *State* *Zip*

Home phone: _____ *Other phone:* _____

Marital Status: ❑ *Married* ❑ *Single* ❑ *Divorced* ❑ *Widowed*

Date of Birth: _____ *Social Security #: (Show card only if needed)*

Place of Birth: _____ *Previous Occupation:* _____

Primary Language: ❑ *English* ❑ *Other* _____

Are you a Veteran? ❑ *Yes* ❑ *No* *Are you a Spouse of a Veteran?* ❑ *Yes* ❑ *No*

Name of second applicant (If applicable) _____

Address: (Leave blank if same as above) _____
Street *City* *State* *Zip*

Home phone: _____ *Other phone:* _____

Marital Status: ❑ *Married* ❑ *Single* ❑ *Divorced* ❑ *Widowed*

Date of Birth: _____ *Social Security #:* _____

Place of Birth: _____ *Previous Occupation:* _____

Primary Language: ❑ *English* ❑ *Other* _____

How did you hear about Norse Home? _____

What type of residency are you applying for? ❑ *Independent* ❑ *Assisted Living*

When were you interested in residence? ❑ *0-3 months* ❑ *3-6 months* ❑ *6-12 months*

❑ *Other:* _____

What was the deciding factor for choosing the Norse Home? _____

_____

_____

_____

_____

Resident Name: _____

EMERGENCY CONTACT INFORMATION

Primary Emergency Contact

Name: _____
Last First Middle

Address: _____
Street City State Zip

Relationship: _____ Home Telephone: _____

Who else should be notified in case of an emergency? *(Need at least 2 emergency contacts)*

Name: _____
Last First Middle

Address: _____
Street City State Zip

Relationship: _____ Home Telephone: _____

Name: _____
Last First Middle

Address: _____
Street City State Zip

Relationship: _____ Home Telephone: _____

ADVANCE DIRECTIVES/LEGAL REPRESENTATION

Do you have a Durable Power of Attorney for: **Health Care** ❑ Yes ❑ No **Financial** ❑ Yes ❑ No

Health Care representative:

Name of person(s) _____

Relationship: _____

Financial representative: (if different):

Name of person(s) _____

Relationship: _____

Do you have a Living Will? ❑ Yes ❑ No Do you have a POLST? ❑ Yes ❑ No

Please Supply a copy of these documents for our records.

Resident Name:_____

HEALTH PROVIDERS

Primary Care Physician: _____ Phone :_____ Fax:_____

Address: _____

Street City State Zip

Most Recent Visit: _____ Any current needs? _____

_____

Other Medical Care Professionals (❑ Dentist, ❑ Podiatrist, ❑ Audiologist, ❑ Optometrist or ❑ other specialists?)

Care Provider Name: _____ Phone: _____

Type of Provider: _____

Address: _____

Street City State Zip

Most Recent Visit: _____

Care Provider Name: _____ Phone: _____

Type of Provider: _____

Address: _____

Street City State Zip

Most Recent Visit: _____

Care Provider Name: _____ Phone: _____

Type of Provider: _____

Address: _____

Street City State Zip

Most Recent Visit: _____

Care Provider Name: _____ Phone: _____

Type of Provider: _____

Address: _____

Street City State Zip

Most Recent Visit: _____

Resident Name: _____

RESIDENT HEALTH HISTORY

Are you on a special diet? ❑ *Yes* ❑ *No*

If yes, explain: _____

_____

_____

Have you been in any kind of health care setting in the last year? (i.e. Adult Home, Assisted Living, Skilled Nursing Facility/Rehabilitation Center, Hospital)

❑ *Yes* ❑ *No* *If yes, explain:* _____

_____

_____

Do you require special health equipment? (For example: Walker, Cane, Wheelchair, Oxygen, Raised Toilet Seat, etc.) ❑ *Yes* ❑ *No*

If yes, explain: _____

_____

_____

Other information that you would like us to know in order to help you here at the Norse Home:

_____

_____

_____

_____

_____

_____

_____

_____

_____

In accordance with State Law 901-I, this is a non-smoking building.

Resident Name: _____

BILLING/BUSINESS MAIL INFORMATION

I would like my business mail delivered directly to me ❑ Yes ❑ No

If No, please send to:

Name: _____
Last First Middle

Address: _____
Street City State Zip

Relationship: _____ Home phone: _____

Work Phone: _____ Cell Phone _____

Email Address: _____

I am responsible for my own financial matters; please send the statement to me directly.

❑ Yes ❑ No

(If no) I want my statements sent to:

Name: _____
Last First Middle

Address: _____
Street City State Zip

Relationship: _____ Home phone: _____

Work Phone: _____ Cell Phone _____

Email Address: _____

I still would like a copy of my statement for my own records: ❑ Yes ❑ No

Insurance Information:

Medicare # _____ I have ❑ Part A ❑ Part B ❑ Part D (Which Plan?)

or Managed Care _____ ID #: _____

Medicaid # _____ (Show Card)

Other Insurance Coverage: _____ ID #: _____

Long Term Care Insurance: _____

PLEASE PROVIDE COPIES OF INSURANCE CARDS AND MEDICARE CARD

Resident Name: _____

FINANCIAL STATEMENT

MONTHLY INCOME	
Source	**Monthly Amount**
Social Security	
Pension/Annuity	
Other:	
Other:	
Other:	

ASSETS	
Source	**Amount**
Real Estate	
Bank Balances	
Investments (Stocks/Bonds)	
Other:	
Other:	
Other:	

How will your Norse Home account be paid upon beginning residency?

❑ *Private Pay* ❑ *Medical or Long Term Care Insurance:* _____

APPLICANT AUTHORIZATION

I understand and agree that the foregoing information and Financial Statement are true statements of fact to the best of my knowledge and belief, are submitted as part of my application for residency at the Norse Home. I understand that the application is not a contract or reservation for residence.

I understand that all of this information will be treated as confidential and will not be disclosed to others without my authorization except to conduct the business of the Norse Home.

Applicant Signature: _____

Or Legal Representative: _____

Relationship to applicant: _____

Date: _____