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norsehome

A Retirement & Assisted Living Community

Application for Residency

CONFIDENTIAL

5311 Phinney Ave North
Seattle, WA 98103
www.norsehome.org
(206) 781-7400

Name of Applicant: _____

Date of application: _____

Office Use:

Received by: _____

Approved by: _____ **Date:** _____

GENERAL INFORMATION

Name: _____
Last First Middle

Address: _____
Street City State Zip

Home phone: _____ Cell phone: _____

E-mail: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Date of Birth: _____ 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: _____ Cell phone: _____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Date of Birth: _____ 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 a residence? ❑ 0-3 months ❑ 3-6 months ❑ 6-12 months

❑Other: _____

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

_____

_____

EMERGENCY CONTACT INFORMATION

Resident Name: _____

Primary Emergency Contact

Name: _____
Last First Middle

Address: _____
Street City State Zip

Relationship: _____ Cell Phone: _____

Cell Phone: _____ E-mail:_____

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

Name: _____
Last First Middle

Address: _____
Street City State Zip

Relationship: _____Home Phone: _____

Cell Phone: _____ E-mail:_____

Name: _____
Last First Middle

Address: _____
Street City State Zip

Relationship: _____Home Phone: _____

Cell Phone: _____ E-mail:_____

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 Directive to Physician (Living Will)?

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

Please provide a copy of these documents for our records.

HEALTH PROVIDERS

Resident Name: _____

Primary Care Physician: _____ Phone: _____

Fax: _____

Address: _____
Street City State Zip

Most Recent Visit: _____ Any current needs? _____

_____

Other Medical Care Professionals (such as dentist, podiatrist, audiologist, optometrist, cardiologist)

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: _____

Funeral Home Preferred: _____

Have funeral arrangements been made? ❑ Yes ❑ No

BILLING/BUSINESS MAIL INFORMATION

Resident Name: _____

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: _____

In regards to Norse Home bills, please send my bills directly to (otherwise they will be put in my mailbox):

Name: _____
Last First Middle

Address: _____
Street City State Zip

Relationship: _____ Home phone: _____

Work Phone: _____ Cell Phone _____

Email Address: _____

Insurance Information:

Medicare # _____ I have ❑ Part A ❑ Part B

❑ Part D (Which Plan?) _____

Managed Care _____ ID #: _____

Medicaid # _____

Other Insurance Coverage: _____ ID #: _____

Long-Term Care Insurance: _____ ID#: _____

PLEASE PROVIDE COPIES OF INSURANCE CARDS, MEDICARE AND MEDICAID CARDS

FINANCIAL INFORMATION

Resident Name: _____

Financial information of: _____

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

ASSETS	
Source	**Amount**
Real Estate	
Bank Balances	
Investments (Stocks/Bonds)	
Other:	
Other:	
Other:	
Total Assets	
LIABILITIES	
Source	**Amount**
Mortgage	
Credit card	
Notes or other debt	
Other:	
Other:	
Other:	
Total Liabilities	
Net Worth	

Please provide who will be financially responsible for your Norse Home rent and services. If it is someone other than yourself, please have them complete the information above and indicate who's financial information is being provided.

Name of person(s) financially responsible for Norse Home bills: _____

_____

Resident Name: _____

How will Norse Home be paid upon beginning residency?

❑ Private Pay ❑ Long-Term Care Insurance:_____

❑ Medicaid

If you are in the process of applying for Medicaid, please provide information as to when application was submitted, status and how Norse Home will be paid until Medicaid is approved.

_____

_____

APPLICANT AUTHORIZATION

I understand and agree that the foregoing information are true statements of fact to the best of my knowledge and belief, which 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 also understand all decisions about my acceptance at Norse Home will be made by Norse Home staff based on my application, medical status and ability to pay.

I understand that 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: _____

Signature of person financially responsible if other than Resident:

_____

Relationship to applicant: _____

Date: _____