Application for Residency

Date: ____________________

Name: ____
(Last name) (First name) (M.I.) (Maiden)

Current address: ____

Telephone number: ____________________ E-mail (if applicable): ______________________

Expected admission date: ____________________

Personal

1. Social Security No.: ____________________________

   Medicare No.: ______________________________

   Other Insurance/ID No.: _________________________

2. Date of birth: ______________
   (MM/DD/YY)

3. Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widow(er)

4. Are you or your spouse a veteran? ☐ Yes ☐ No If yes, what Branch: __________________

5. Have you applied for Aid & Attendance benefits? ☐ Yes ☐ No

6. Religious affiliation: ____

   Parish/Church: ____

7. Former occupation: ____

8. Highest level of education completed: ____

Emergency Contacts

Contact #1

Name: ______________________________ Relationship: ______________________________

- ☐ POA—Healthcare
- ☐ POA—Finance

Phone number: ______________________ Alternative number: ______________________

E-mail: __________________________________

Contact #2

Name: ______________________________ Relationship: ______________________________

- ☐ POA—Healthcare
- ☐ POA—Finance

Phone number: ______________________ Alternative number: ______________________

E-mail: __________________________________

Contact #3

Name: ______________________________ Relationship: ______________________________

- ☐ POA—Healthcare
- ☐ POA—Finance

Phone number: ______________________ Alternative number: ______________________

E-mail: __________________________________

If the above person(s) cannot be reached, the following person should be notified:

Name: ______________________________ Relationship: ________________________________

Phone number: ______________________ E-mail: _____________________________________

Address: ____

Miscellaneous

1. Who will assist you with shopping arrangements/errands as needed? ___________________________

2. Do you have a burial trust established? ☐ Yes ☐ No

   Name of your funeral home: ____

3. Has Adult Protective Services been involved in your care at any point? ☐ Yes ☐ No

4. Please list your last two places of residence. (List most recent first.)

Past residence #1

Address: ____

City: ________________________________ State: _________ Zip: ______________________________

Past residence #2

Address: ____

City: ________________________________ State: _________ Zip: ______________________________

5. Did someone recommend The Gardens of Hartford?

☐ Family member ☐ Friend ☐ Staff ☐ Physician ☐ Other: __________________________

6. If not, how did you hear about The Gardens of Hartford?

____

Medical

Name of Physician: ______________________________

Name of Dentist: ________________________________ Date of last visit: ______________________

Name of Podiatrist: ________________________________

Name of Eye Clinic/Ophthalmologist: ________________________________

Name of Mental Health therapist/Psychologist/Psychiatrist: __________________________________

Hospital of choice: ________________________________

Are you currently receiving supportive services? ☐ Yes ☐ No

If yes, what kind: ____

Past medical history (please include any major health issues and/or surgeries and dates):

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Please Note:

Prior to or on the day of admission, The Gardens of Hartford will request a copy of the following resident information:

- **Social Security card**
- **Medicare card**
- **Other private insurance card(s)**
- **Power of Attorney for Health Care**
- **Advance Directives**
- **Living Will**
- **Power of Attorney for Finance**
- **Guardianship**

I certify that the information in this application is true to the best of my ability. The undersigned hereby applies for admission and agrees, if admitted, to comply with all current and future policies and procedures of The Gardens of Hartford.

Signature of Applicant: ____ Date: __________________

Signature of Responsible Party: _________________________________ Date: __________________

This application should be completed prior to the nurse assessment. Thank you!