

Application for Admission

I. Personal Information

Full Name of Applicant

Date of Birth

Gender

Current Address

City

State

Zip

Home

Cell

Work

Email

Add to monthly e-newsletter?

Yes

No

Marital Status:

Married

Partnered

Widowed

Divorced

Single

If applicable, name of spouse/partner

Primary Language Spoken

Religious Identification

Military Service?

Yes

No

If yes, which branch?

Name of Contact Person (if different from applicant)

Contact's Address

Relationship to Applicant

City

State

Zip

Home

Cell

Work

Email

Add to monthly e-newsletter?

Yes

No

Please describe why you are applying for admission at Forest Hills:

II. Health Insurance Information

***On admission, please bring your Medicare and/or other health insurance cards*

Social Security Number

Medicare number

Please note ending (Medicare A, B or D?)

Medicaid Number, if applicable

State of Medicaid eligibility

Name of other Health Insurance Company

Policy Number

Group Number

Name of Insured

Effective Date

Longterm Care Insurance Company, if applicable

Policy Number

Benefit Amount

Benefit Term

III. Power of Attorney & Health Care Proxy

***On admission, please bring a copy of your Power of Attorney & Health Care Proxy documents*

Name of Financial Power of Attorney

Current Address	Relationship to Applicant
City	State Zip
Home	Cell Work
Email	Add to monthly e-newsletter? Yes No

Name of Health Care Proxy

Current Address	Relationship to Applicant
City	State Zip
Home	Cell Work
Email	Add to monthly e-newsletter? Yes No

Do you have Advanced Directives? Yes No *If yes, please provide a copy for Admissions*

IV. Physician Information

Name of Physician _____ **Name of Practice**

Physician Address

City State Zip

Work Phone Cell Phone

V. Medical Specialist Information

Please list all medical specialists (Cardiologist, Dentist, etc.) and insert additional pages if needed.

1. Name of Specialist **Name of Practice**

Type of Specialist

Physician Address

City State Zip

Work Phone Cell Phone

2. Name of Specialist **Name of Practice**

Type of Specialist

Physician Address

City State Zip

Work Phone Cell Phone

VI. Emergency Contact Information

In case of emergency, please contact the following person:

Name	Relationship to Applicant		
Current Address			
City	State	Zip	
Home	Cell	Work	
Email	Add to monthly e-newsletter?	Yes	No

If the person listed above is unavailable, please contact the following person:

Name	Relationship to Applicant		
Current Address			
City	State	Zip	
Home	Cell	Work	
Email	Add to monthly e-newsletter?	Yes	No

VII. Health & Medical Information

Do you have any medication allergies? If so, please describe

Do you have a chronic illness or disability? If so, please describe

VIII. Special Interests & Hobbies

What do you like to do for fun?

What are your favorite movies/TV shows?

What are your favorite books?

What religious services (if any) would you like to participate in at Forest Side?

IX. Dining Preferences & Requirements

Do you have any food allergies? If so, please describe

Do you require a special diet? If so, please describe

X. Application Agreement

I hereby warrant that the information set forth in this Application is accurate and complete to the best of my knowledge.

I understand that the Executive Committee will determine the admission of the Applicant based on this Application, the Applicant's interview, and the health, medical and financial information of the applicant.

XI. Signed

Signature of Applicant or Representative

Date

Printed Name of Applicant or Representative

Signature of Forest Side Representative

Date

Printed Name of Forest Side Representative

For Office Use:

Date Application Received _____ Date of Interview _____ Date of Move-In _____