

App # _____

FOSS VILLAGE APPLICATION FOR RESIDENCY

GENERAL INFORMATION

Application Date _____ Contact Person _____ Phone _____

I am interested in residency:

Now (I would like to be contacted for an assessment when a unit becomes available.)

Future (Application will be kept on file until I contact Foss Village to activate.)

Name _____ Phone _____
Last First MI

Permanent Address _____

City, State Zip _____

How long at this address? _____ Do you rent? _____ Own? _____

Birth Date _____ Birth Place _____

Social Security # _____ Medicare # _____

Marital Status: Married Single Separated Divorced Widowed

Current or former occupation _____

Will you be bringing your automobile with you to Foss Village? Yes No

If yes, what is the make, model, & license number? _____

| How did you hear about us? | Name of Referral |
|--|------------------|
| <input type="checkbox"/> Ad | _____ |
| <input type="checkbox"/> Agency | _____ |
| <input type="checkbox"/> Physician | _____ |
| <input type="checkbox"/> Friend | _____ |
| <input type="checkbox"/> Family member | _____ |
| <input type="checkbox"/> Other | _____ |

MEDICAL INFORMATION

Do you have a Durable Power of Attorney for Health Care? Yes No

If yes, name: _____ Phone _____

Primary Physician _____ Phone _____ Fax _____

Office Address _____

Physician Specialist _____ Phone _____ Fax _____

Office Address _____

If applicable:

Dentist _____ Phone _____ Fax _____

Eye Doctor _____ Phone _____ Fax _____

Podiatrist _____ Phone _____ Fax _____

List of primary diagnoses: _____

Do you currently smoke? Yes No If No, did you ever smoke? Yes No

If Yes, when did you quit? _____

Do you drink alcoholic beverages? Yes No

Do you have Medical Insurance? Yes No

| <u>Name and Address of Medical Insurer(s)</u> | <u>Policy No.(s)</u> |
|---|----------------------|
| _____ | _____ |
| _____ | _____ |

FINANCIAL INFORMATION

Do you have a Durable Power of Attorney for Finances? [] Yes [] No

If yes, name: _____ Phone _____

Are you presently eligible for the Assisted Living Medicaid/COPEs program? [] Yes [] No

| <u>Monthly Income</u> | <u>Monthly Amount</u> | <u>Assets</u> | <u>Total Amount</u> |
|-----------------------|-----------------------|---|---------------------|
| Salary/Wages | _____ | Real Estate | _____ |
| Social Security | _____ | Bank Balances | _____ |
| Pension Annuity | _____ | Investments <i>(stocks and/or bonds)</i> | _____ |
| Other Income | ===== | Other Assets | ===== |
| Total Monthly Income | _____ | Total Assets | _____ |

Person responsible for receipt and payment of billing statements:

Name

Relationship

Address

Home Phone

City, State, Zip

Business Phone

I understand and agree that the foregoing application is not a contract or reservation for residence. Nothing contained herein is binding on either party until a Residency agreement has been signed by the parties hereto. The applicant hereby authorizes any credit-reporting agency to provide credit history to Foss Village.

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

Applicant Signature _____

Legal Representative _____

Relationship to Applicant _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

FOSS HOME AND VILLAGE

Name of Applicant: _____ Date of Birth: _____

I authorize the release of my medical information to Foss Home and Village so that Foss Village may conduct a pre-admission assessment at the time that I am being considered for admission. I understand the purpose of this assessment is to assist Foss Village in determining if I am appropriate for residence in their community. I understand that the type of information released will be that medical information which is pertinent and necessary for the staff of Foss Village to have in order to successfully complete the pre-admission assessment.

I further authorize Foss Home and Village to request the information described above from the following medical personnel: *(please list names and phone numbers for all pertinent medical personnel who may have information helpful in our pre-admission assessment)*

This authorization will expire on the following date or upon the occurrence of the following event: _____

If both a date and an event are provided, the authorization will expire on whichever occurs later.

I understand I may revoke this authorization in writing at any time, except to the extent that Foss Home and Village has already taken action in reliance on this authorization.

By signing below, I acknowledge that I have read and understand this authorization form.

Signature of Applicant or Authorized Representative Date

If signed by authorized representative, please print name and describe relationship to applicant or other authority to act.

Name Relationship to Applicant