Libby Bortz
Assisted Living

Application for Residency

Date: _____

I. General Information

Name: _____ Phone: (_____) _____

Current Address: _____

City/State/Zip: _____

Gender: M ☐ F ☐ Date of Birth: _____/_____/_____ Age: _____

Social Security #: _____-_____-_____

Marital Status (please click): ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Present Living Arrangements (ie: Alone, Another Facility, With Relatives):

_____

Primary Contact for Application Process

Name: _____ Relationship:_____

Address: _____

City/State/Zip: _____

Phone: (_____) _____ Work Phone: (_____)_____

E-Mail Address: _____

Advanced Directive Information

Power of Attorney: ☐ Yes ☐ No Name: _____

Guardianship: ☐ Yes ☐ No Address: _____

Conservator: ☐ Yes ☐ No City/State/Zip: _____

Phone: (_____)_____

Please attach copies of documentation showing POA, guardianship, and/or conservatorship, if applicable. This information is required pursuant to [insert reason.]

II. Medical Information Resident Name: _____

This information is required pursuant to Colorado state regulations

Physician Information

Name: _____

Clinic: _____

Address: _____

City/State/Zip: _____

Phone: (_____)_____ Fax: (_____)_____

Other Medical Provider: _____ Phone: (_____)_____

Health Insurance: _____ Policy #:_____ Group#: _____

Secondary Info: _____

Please provide copy of health insurance cards

Diagnosis:

_____

_____

_____

Allergies: _____

Medications (Prescribed): _____

_____ _____

_____ _____

_____ _____

Non-Prescription Medications (such as pain relievers, antacids, vitamins):

_____ _____

_____ _____

_____ _____

_____ _____

III. Physical Status Resident Name: _____

1. Are you able to ambulate without assistance? ☐ Yes ☐ No

   Do you utilize a cane? ☐ walker? ☐ wheelchair? ☐

   Explain any mobility difficulties:

   _____

2. Are you able to bathe without assistance? ☐ Yes ☐ No

   Explain any bathing difficulties:

   _____

3. Are you able to dress without assistance? ☐ Yes ☐ No

   Explain any dressing difficulties:

   _____

4. Are you able to eat without assistance? ☐ Yes ☐ No

   Explain any eating difficulties:

   _____

5. Are you able to handle all of your toileting needs without assistance? ☐ Yes ☐ No

Explain any toileting difficulties:

_____

6. Other information regarding physical status:

_____

_____

Emergency Information Contact Sheet

Resident Name: _____ Apt. #: _____

Date of Birth: _____ Soc. Sec. #: _____

Physician Name: _____ Phone: (_____)_____

Address: _____ City/State/Zip: _____

Hospital Preference: _____

Burial Arrangements: _____ Phone #: _____

Special Information or Instructions:

_____

_____

Emergency Contact

1. Name: _____ Relationship: _____
   Address: _____ City/State/Zip: _____
   Phone: (_____)_____ Work Phone: (_____)_____
   Pager: (_____)_____ Cellular: (_____)_____
2. Name: _____ Relationship: _____
   Address: _____ City/State/Zip: _____
   Phone: (_____)_____ Work Phone: (_____)_____
   Pager: (_____)_____ Cellular: (_____)_____

3. Name: _____ Relationship: _____

Address: _____ City/State/Zip: _____

Phone: (_____)_____ Work Phone: (_____)_____

Pager: (_____)_____ Cellular: (_____)_____

Insurance Information

Health Insurance Provider: _____ Policy #: _____

Supplemental Ins. Carrier: _____ Policy#: _____

Miscellaneous Information:

Religion Preference: _____ Church: _____

Clergy's Name: _____ Phone#:_____

Address: _____

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I hereby certify that all information contained on this application is correct and complete to the best of my knowledge and that any misrepresentation of material will result in my being ineligible for admission.

I agree to give The Libby Bortz Assisted Living Center the authority to investigate any income and/or asset sources necessary to determine eligibility and to verify the above stated information.

_____ _____

Applicant's Signature Date

_____ _____

Responsible Party Signature Date

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It is illegal to discriminate against any person based on race, religion, sex, national origin, familial status or handicap.

EQUAL HOUSING OPPORTUNITY