SENIOR HOUSING WITH A *HEART*

NORTHAVEN

Est. 1972

Assisted Living Resident Application

Date: _____

Full Name of Applicant: _____

Age: _____ Birthday: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____

Northaven Assisted Living is a non-smoking community.

Do You Smoke? Yes ☐ No ☐

Name, Address, and Phone of Contact Person: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____

Relationship to Applicant: _____

Name, Address, and Phone of Power of Attorney or Guardian: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: Home: _____ Cell: _____

How Soon Are You Hoping to Move to Northaven Assisted Living?

_____

Reason for Moving to Assisted Level of Care:

_____

Are You Currently Receiving Medicaid - COPES? Yes ☐ No ☐

If no, Do You Anticipate Applying for Medicaid - COPES in the next six Months? Yes ☐ No ☐

Please List Approximate Dates and Reasons For Hospitalizations or Nursing Home/Adult Family Home Admissions in the Last 2 Years. ***(Please include a second page if necessary,)***

_____

_____

_____

How Did You Hear About Northaven Assisted Living?

_____

Primary Care Provider: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____

Assisted Living Resident Application

Name(s) of Other Healthcare Providers/Physcians:

Please List Current Diagnoses/Chronic Health Conditions:

How Would You Rate Your Current Health Status?

☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ Not sure at this time

Services You Anticipate You Will Need at Northaven Assisted Living:

☐ Medication Assistance
☐ Dressing Assistance
☐ Memory Assistance/Cueing
☐ Incontinence Care
☐ Special Dietary or Nutritional Needs
☐ Bathing/Showering Assistance
☐ Laundry Assistance
☐ Mobility Assistance
☐ Toileting Assistance
☐ Transportation

Please Describe Any Additional Services You May Need:

*Please Attach a List of all Current Medications/Supplements You Take.

List Any Allergies to Medications:

I authorize the release of medical information from healthcare providers for review for assessment purposes prior to move-in/admission to Northaven Assisted Living.

Signature of Applicant _____ Date _____

Signature of Representative (Relationship) _____ Date _____