# APPLICATION FOR RESIDENCY

**Golden Options Care, LLC**

## GENERAL INFORMATION

Name: _____Social Security # _____

Address:_____City:_____State:_____Zip: _____

How long at this address? _____(yrs/months) Contact Phone#: _____

Birth Date: ___/___/_____ Birth Place: _____

Gender: M [ ] F [ ] Marital Status: (Circle one) **Married Single Widower Divorced Separated**

## EMERGENCY CONTACT

Name:_____ Relationship: _____

Address: _____

Home Phone:_____ Cell Phone: _____Email: _____

Name of Power of Attorney:_____ or Guardian: _____

Name of Health Care Proxy: _____

(Please attach documentation for Power of Attorney, Guardian or Health Care Proxy if they exist)

## CURRENT LIVING SITUATION (check one):

[__] own my home [__] renting [__] Assisted Living [__] Nursing Home [__] Rehab Center [__] Hospital

[__] Other, please explain _____

If renting, Monthly rent: $_____ Owner/Landlord: _____

Address:_____ City: _____

State:_____ Zip code:_____ Telephone: _____

Do you own a car? Yes [ ] No [ ] Do you drive regularly? Yes [ ] No [ ]

Do you intend to maintain a car? Yes [ ] No [ ]

Are there any problems or concerns in which our staff should be aware of or any special support you might need to live in our facility? _____

_____

_____

_____

## MEDICAL AND INSURANCE INFORMATION

Physicians Name: _____Address: _____

Telephone: _____

Hospital Affiliation: _____

How would you describe your present state of health?

_____

_____

_____

How often do you see your doctor? _____When was your last visit? _____

How much walking do you do? _____Any difficulty with stairs? Yes ____No____

Please check off any of the following that you use: Cane [ ] Walker [ ] Wheelchair [ ]

Are you on any medications at the present time? Yes [ ] No [ ] If yes, please specify the medications and the conditions being treated (use separate paper if needed):

_____

_____

_____

_____

_____

Do you require assistance with medications? Yes [ ] No [ ] If no, please provide a physician's statement to state you can administer/manage your own medications.

Are you on a special/restricted diet? Yes [ ] No [ ] If yes, please describe:

_____

_____

_____

Do you have a: living will/DNR/COMFORT ONE/Physicians Orders for Life-Sustaining Treatment (POLST)?

Yes [ ] No [ ] If yes, please provide copies.

*Insurance continued*

Please list all of your medical insurance coverage's, including supplemental health insurance:

Medicare: _____Policy # (Required): _____

Health Insurance: _____Policy # (Required): _____

**Daily Living** Please use an "X" to indicate your ability for the tasks listed below:

| TASK | "I can handle myself" | "I need some assistance" | COMMENTS |
|---|---|---|---|
| Bathing | | | |
| Dressing | | | |
| Mouth /Skin Care | | | |
| Shaving/Grooming | | | |
| Toileting | | | |
| Escort/Mobility | | | |
| Med Reminders | | | |
| Housekeeping | | | |
| Clothing Management | | | |
| Night Care | | | |

Is there any other information we should be aware of when reviewing your health and medical concerns?

_____

_____

_____

I understand and agree this application is neither a contract, nor a reservation for residence. Nothing contained in this document is legally binding for me or the facility to which I am applying for residency, until a Residency Agreement has been approved and signed by all parties involved.

_____ _____

Signature of Applicant Date

## MEDICAL INFORMATION

**MEDICAL RELEASE**

**FAMILY: PRESENT THIS TO YOUR PHYSICIAN AFTER COMPLETING THIS SECTION**:

I, _____, hereby authorize my physician _____to
(family representative) (print physicians name)

Completely and fully answer all questions under the Physician's Statement as part of my application for residence at

Golden Options Care Assisted Living, 12 Bessler Rd, Montana City, Montana 59634

_____ _____
Applicant/ Representative's Signature Date

Applicant(s) Name: (Print):_____ Social Security #: _____

Address:_____

City:_____ State:_____ Zip:_____ Telephone:_____

## PHYSICIAN'S STATEMENT

**FAX COMPLETED FORM TO : (406) 422-4643**

Please indicate **Primary Diagnosis:** _____

_____

**Additional** Diagnosis: _____

Significant past medical history:_ _____

Present **Mental** status (e.g., confusion, long/short term memory, depression, etc.): _____

_____

_____

Is applicant orientated to: **Time:** Yes [ ] No [ ] **Place:** Yes [ ] No [ ] **Person:** Yes [ ] No [ ]

Is the applicant free and clear of communicable diseases? Yes [ ] No [ ]

Please describe any **Behavioral** concerns which might help in our care planning: _____

_____

_____

Current **Medications**/Dosages/uses: _____

_____

_____

Known **Allergies**: _____

Is applicant **able to follow** prescribed medical regime? Yes [ ] No [ ]

Please describe any **sensory impairments: Vision:** _____

**Hearing**: _____

**Blood pressure** reading: _____

Has **any illness** occurred during the past 5 years resulting in impaired physical or mental health?

_____

_____

**Hospitalization(s)** during the last 5 years? Yes [ ] No [ ] Reason(s): _____

_____

_____

Is applicant on a special **diet?** Yes [ ] No [ ] If Yes, explain dietary restrictions & how we might comply? _____

_____

_____

Please indicate applicants need for assistance with **activities of daily living:** _____

_____

_____

**Is the applicant continent of: Bladder: Yes [ ] No [ ] and Bowel: Yes [ ] No [ ]**

Does the resident use any appliances or durable **medical equipment:** _____

_____

Walker: Yes [ ] No [ ] Cane: Yes [ ] No [ ] Wheelchair: Yes [ ] No [ ] Other: _____

_____

*Other medical equipment continued*

_____

Please identify **other special needs** that resident may require and how they might be accommodated: _____

_____

_____

Additional Comments: _____

_____

_____

_____

**Primary Physician's (signature)**: _____

**Physican's Name (printed)**: _____

City:_____State:_____Zip:_____Phone: _____

**FINANCIAL INFORMATION**

Please complete the following financial information to assist Golden Options Care Assisted Living:

Applicant(s) Name(s)

(Last) _____ (MI) _____ (First) _____

(Last) _____ (MI) _____ (First) _____

Address: _____City: _____State: _____Zip: _____

Phone: (_____)_____ Date of Birth: _____/_____/_____ Social Security #: _____

If applying with spouse, are all assets held jointly? Yes_____ No_____ (if No, complete separate form)

**INCOME SOURCES:**

The following worksheet is necessary to determine if your financial resources are adequate to cover the monthly living costs (this information is kept confidential).

Employment Income: $_____per month

Social Security: $_____per month

Employer Pension: $_____per month

Interest & Dividend: $_____per month

Annuity Income: $_____per month

Life Insurance Benefits: $_____per month

Support from Family: $_____per month

Rental Income: $_____per month

Other: $_____per month

**Total Income: $_____per month**

Is there is any additional information we should be aware of when reviewing your financial resources? _____

_____

_____

**REAL ESTATE/PROPERTY/OTHER ASSETS:** (please attach additional sheets as necessary)

Type/Description Date Acquired

_____ _____

Owners Current Market Value

_____ _____

**LIABILITIES:** Account/Type Name of Lender Amount Owed

Home Mortgage _____ _____ _____

Other _____ _____ _____

Total Liabilities: $_____

With your current income and financial resources, how long do you feel you will be able to afford monthly rents?

_____

Who will be responsible for payment of your bills? Self_____ Other Person (name): _____

Address of "other person": _____

City: _____ State: _____ Zip: _____

Relationship (e.g. Power of Attorney, Conservatorship): _____

Have you designated someone with Financial Power of Attorney to manage your affairs? Yes_____ No _____

If yes, please describe type of power given (i.e. financial, durable, medical, general, limited, conservator, guardian) and list name, address, and phone number of person who holds such power. Please furnish a complete copy of the authorizing document as well as any trust documents, wills and codicils which may pertain to these Powers.

**Type of Power of Attorney:**_____

Held by (Name): _____ Relationship: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip code: _____

I certify the information provided in this Financial Information form is true and correct. I understand that any false statements or misrepresentations or omissions may result in cancellation of my application or nullification of my Resident Agreement. I authorize Golden Options Care, LLC to conduct a review of my financial status and any information necessary to verify my ability to pay for my residency, including credit reports, etc. I further agree to provide any additional written comments required to confirm such information and to cooperate with Golden Options Care, LLC in providing information. I understand that it will be necessary to update this for if there are any material changes in my finances.

_____ _____ _____

Applicant Signature Date

*If this form is being completed by someone other than the applicant for residency, please print name of person completing information for the applicant, and sign on the line below. Attach a copy of the Power of Attorney or other documentation authorizing a person to act on the applicant's behalf.*

Name: _____ Relationship: _____

_____ _____

Signature Date