APPLICATION

☐ **Aspiri Garden Apartments** (Assisted Living)
☐ **Beardsley Terrace** (Skilled Nursing)
☐ **Break Time** (Adult Day Care Program)

Vashon Community Care
Senior Living Choices

1. BASIC INFORMATION

Full Name		Birth Date	Age
What do you prefer to be called?		Phone	
Current Address			
City/State/Zip		Religious Preference (Opt)	
Veteran/Spouse of ☐ Yes ☐ No		Language	Career
Marital Status		Social Security #	
Long Term Care Insurance ☐ Yes ☐ No		If yes, name of insurer	
Medicare #		Medical Insurance	
Medicaid #		Medicare Plan D Plan (name)	
DPOA Designated ☐ Yes ☐ No		If yes, name/relationship of DPOA	
Advanced Directives (POLST form, Living Will, Directive to Physicans, Five Wishes) ☐ Yes ☐ No			

2. CONTACTS: HEALTHCARE PROVIDERS

Primary Doctor	Phone
Address	Fax
Dentist	Phone
Address	Fax
Other Health Care Provider	Specialty
Address	Phone
If you have other health care providers, please list at the end of this form	

3. CONTACT INFORMATION

Name		Relationship
Address		City/State/Zip
Home Phone	Work Phone	
Cell Phone	Email Address	

First Alternate Contact

Name		Relationship
Address		City/State/Zip
Home Phone	Work Phone	
Cell Phone	Email Address	

Second Alternate Contact

Name		Relationship
Address		City/State/Zip
Home Phone	Work Phone	
Cell Phone	Email Address	

Mail Billing Statement to

Name		Relationship
Address		City/State/Zip
Home Phone	Work Phone	
Cell Phone	Email Address	

DAILY LIVING INFORMATON

Vashon Community Care
Senior Living Choices

Name

Please complete this questionnaire so that we may better get to know you, your preferences and needs (if any).

Current Functioning

	Always	Often	Sometimes	Rarely	Never
Can you communicate your needs/preferences effectively?					
Do you do your own cooking?					
Do you do your own housework?					
Do you do your own laundry?					
Do you drive?					
If you don't drive, do you make your own transportation arrangements?					
Do you have an Access Bus Card? ☐ Yes ☐ No					
Do you arrange for your own medical appointments?					
Do you need assistance with taking medications or with other medical treatments?					
Do you need or want help getting up and getting dressed in the morning or undressing and getting ready for bed at night?					
Do you use anyting to help you get around? ☐ Cane ☐ Walker ☐ Wheelchair					
Can you walk up and down stairs?					
Do you need or want any help with bathing?					
Do you have any trouble with your bladder or bowels? ☐ Yes ☐ No If yes, does anyone help you with this?					
Do you smoke? ☐ Yes ☐ No					
Do you have diabetes? ☐ Yes ☐ No If yes, does anyone assist you with diabetes management?					
Do you have any allergies to medications, foods, animals, environment? ☐ Yes ☐ No If yes, please list:					

Current Preferences and Activities

What time do you prefer to go to bed?					
Do you have trouble sleeping at night?					
If so, what do you do when you are up?					
What time do you prefer to get up in the morning?					

DAILY LIVING INFORMATON (continued)

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Current Preferences and Activities (continued)

	Always	Often	Sometimes	Rarely	Never
Do you participate in activities such as exercise, playing cards, visiting with friends?					

What are your favorite activities?

Do you prefer to take your medication at specific times? ☐ Yes ☐ No

If yes, What times do you prefer?

Do you enjoy being around dogs and cats? ☐ Yes ☐ No

Do you enjoy being around other animals? ☐ Yes ☐ No

If yes, what kind of animals?

Do you have any pets? ☐ Yes ☐ No

If yes, what type of pet? What is your pet's name?

For Aspiri Gardens: Will your pet be moving in with you? ☐ Yes ☐ No

What are some of your favorite foods and drinks?

Please list any specific dietary needs or preferences you may have.

Are you living in your own home now? ☐ Yes ☐ No

If not, where are you living?

Is there anything else you would like is to know about you?

Applicant or Representative Signature Date

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Vashon Community Care
Senior Living Choices

Vashon Community Care
15333 Vashon Highway SW
Vashon, WA 98070
206 567-4421 phone
206 567-5052 fax

I hereby authorize:

_____

(Name of physician, practitioner, hospital, retirement community, or health care institution)

_____

Address

_____

City State Zip

_____

Phone Fax

_____

Email

to forward medical/service records, or a summary thereof for

_____

(Name of resident/patient)

To: Vashon Community Care
15333 Vashon Highway SW
Vashon, WA 98070
206 567-4421 phone
206 567-5052 fax

_____

Resident Signature Date

_____

Resident Authorized Respresentative's Signature (if needed) Date