

APPLICATION

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



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 <input type="checkbox"/> Yes <input type="checkbox"/> No	Language	Career
Marital Status	Social Security #	
Long Term Care Insurance <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name of insurer	
Medicare #	Medical Insurance	
Medicaid #	Medicare Plan D Plan (name)	
DPOA Designated <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, name/relationship of DPOA	
Advanced Directives (POLST form, Living Will, Directive to Physicians, Five Wishes)	<input type="checkbox"/> Yes <input type="checkbox"/> 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

PRE-ADMISSION FINANCIAL STATEMENT



Name _____

1. ASSETS

	Name of Bank	Account #	Balance
Checking Account			
Savings Account #1			
Savings Account #2			
	Name	Account #	Balance
Certificate of Deposit #1			
Certificate of Deposit #2			
	Name		Value
Stocks/Bonds			
Stocks/Bonds			
Insurance			
	Location		Value
Property/Real Estate			
Other Assets			
TOTAL ASSETS			

2. LIABILITIES (Home Mortgage, Credit Card, Car Payments, Health/Life Insurance, etc.)

	Name/Address of Creditor	Amount
Home Mortgage		
TOTAL LIABILITIES		

3. SOURCES OF MONTHLY INCOME

	Name of Source	Amount
Social Security		
Pension(s)		
Annuities		
Investment Income		
Other		
TOTAL MONTHLY INCOME		

DAILY LIVING INFORMATION



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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 anything to help you get around? <input type="checkbox"/> Cane <input type="checkbox"/> Walker <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does anyone help you with this?					
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Do you have diabetes? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, does anyone assist you with diabetes management?					
Do you have any allergies to medications, foods, animals, environment? <input type="checkbox"/> Yes <input type="checkbox"/> 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? _____

**AUTHORIZATION TO RELEASE
CONFIDENTIAL INFORMATION**



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 Representative's Signature (if needed) Date