The Golden Crest
A Senior Living Community

Thank you for your interest in The Golden Crest. Please complete and return this application. All information will be kept confidential. Upon receipt of your completed application a member of our team will contact you.

## General Information- Please print

Name_____ Social Security #_____

Address_____

State_____ Zip_____ Phone_____

Date of birth_____ Place of birth_____ Gender M__F__

Marital status Married__ Single__ Widow/er__ Divorced__ Separated__

Primary Language_____ Religion_____

Veteran Status_____ Previous Occupation_____

Medicare #_____ Other Insurance_____

Are you in the process of applying for Medicaid Yes___ No___

## Current Living Situation

Do you Own or Rent? (Please circle) How many years_____

Who resides with Applicant?_____

What is your approximate monthly income? $_____

Do you own a car? Yes___ No___ Do you intend to bring it Yes__ No___

Who helps you at home? _____

How do they help you? _____

Please list agencies and type of assistance they provide_____

Daily Living- Please print

How do you enjoy spending your time/hobbies?

_____

_____

Please use an "X" to describe yourself in the following areas:

| TASK | NO assistance | SOME assistance | Comments |
|---|---|---|---|
| Bathing | _____ | _____ | _____ |
| Dressing | _____ | _____ | _____ |
| Finances | _____ | _____ | _____ |
| Shopping | _____ | _____ | _____ |
| Walking | _____ | _____ | _____ |

What special equipment or devices do you require?

Walker/cane Yes__ No__

Dentures Yes__ No____

Glasses Yes___ No____

Hearing Aides Yes__ No___

Who accompanies you to appointments? _____

Medical Information

Physicians Name_____ Phone # (_____)_____

Address_____ City _____State_____ Zip_____

Mental Health_____ Phone # (_____)_____

Address_____ City _____ State_____ Zip_____

Dentist _____ Phone # (_____)_____

Address_____ City _____State_____ Zip_____

Optometrist_____ Phone # (_____)_____

Address_____ City _____State_____ Zip_____

What medical/health problems do you have? _____

Please provide a list of current medications from your physician.

Will The Golden Crest be supervising your medication? Yes___ No___

Do you require assistance with a special diet or eating? Yes___ No ___

Please provide if so _____

Do you smoke? Yes__ No __

Do you have funeral arrangements? Yes___ No___

Please provide if so: _____

Do you have a Power of Attorney? Y____ N____ If not next of kin:

Please provide

Name_____

Address_____

Telephone _____

Email _____

Who is helping you with your application (if different than above)?

May we contact them? Yes___ No ___

Name_____ Relationship _____

Address_____ Phone _____

**I understand that this application is neither a contract or a reservation for residence. Nothing contained in this document obligates or entitles me to an apartment at The Golden Crest until a Resident Agreement has been signed by all parties involved.**

Signature of Applicant_____ Date_____