SCANDINAVIAN LIVING CENTER

APPLICATION FOR RESIDENCY

Thank you for your expression of interest in residency at the Scandinavian Living Center. Please complete and return this form. Upon receipt of the application, we will contact you to initiate the assessment process in order to determine the appropriateness of our residence to meet your needs. Please note that all information will remain confidential.

I. GENERAL INFORMATION

Applicant Name: _____ Date of Application_____

Address:_____

Phone:_____

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

Gender: Male Female

Marital Status: (Circle One) Married Single Widow/er Divorced Separated

Current or former occupation or profession:_____

Your anticipated move-in date: _____

How did you hear about us? _____

Contact information of the person assisting you as you consider the assisted living option (If applicable):

Name:_____

Address:_____

Phone:_____ Relationship:_____

II. CURRENT LIVING SITUATION

Do you own your own home, or rent? (Circle One) Own Rent Other (please Explain_____

What type of housing do you live in? Apartment Single-Family Multifamily Condo Other_____

Do you own an automobile? Yes No

Do you drive yourself regularly? Yes No Do you intend to maintain a car? Yes No

Do you require someone (friend, relative or other person) to live with you at the present time? If so, who:_____
Reason for this need?_____

If not, is someone currently visiting you during the day (relative, friend, health care professional)? Yes No

Do you smoke? Yes No

What are your interests/hobbies? _____

_____

III. DAILY LIVING

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

Task	Completely Independent	Some Assistance Appreciated	Comments
Preparing Meals	_____	_____	_____
Housekeeping	_____	_____	_____
Laundry	_____	_____	_____
Bathing	_____	_____	_____
Fire Safety	_____	_____	_____
Budgeting	_____	_____	_____
Shopping	_____	_____	_____
Transportation	_____	_____	_____
Dressing	_____	_____	_____
Walking	_____	_____	_____

IV. MEDICAL AND INSURANCE INFORMATION

Physician's Name:_____

Address:
_____

Phone:_____

Are you on any medications at the present time? Yes No

Please list the medications that you take (attach separate sheet if necessary):
_____

_____

_____

Do you require assistance/reminders to administer your medication(s)? Yes No

Please list all of your medical and supplemental insurance:

Insurer:_____ Your ID Number:_____

Insurer:_____ Your ID Number:_____

Insurer:_____ Your ID Number:_____

LONG TERM CARE INSURANCE

Do you have Long Term Care insurance (yes/no)? If yes, please indicate the following:

a. Approximate cash value $_____
b. Length of benefit _____
c. Name of company _____
d. Policy number _____
e. Elimination/waiting period _____

V. CONFIDENTIAL FINANCIAL INFORMATION

Documentation such at form 1040, bank statements, trusts and power of attorney may be required.

Name: _____ Social Security Number: _____/_____/_____

ASSETS

Real estate net value (current value less mortgage balance)	$_____
Savings, CD's and bank accounts	$_____
Investments (stocks, bonds, mutual funds, etc.)	$_____
Equity from trusts and estates	$_____
Other (please note)	$_____
Total Assets	$_____

LIABILITIES

Loans	$_____
Insurance Premiums	$_____
Medical Needs and Supplies (annual)	$_____
Other (please note)	$_____
Total Liabilities	$_____

MONTHLY INCOME

Employment Income	$_____ per month
Social Security Income	$_____ per month
Annuities	$_____ per month
Employer Pension	$_____ per month
Interest and Dividends	$_____ per month
Trusts	$_____ per month
Life Insurance Benefits (cash value)	$_____ per month
Rental Income	$_____ per month
Support from Family	$_____ per month
Veteran's Benefits	$_____ per month
Other (please note)	$_____ per month
Total Monthly Income	$_____ per month

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

_____

_____

RESPONSIBILITY FOR PAYMENT

Who will be responsible for payment of applicant's bills? Self___ Other ___
(If "other," please indicate the following):
Name:_____
Address:_____
Phone Number: ( )_____ Relationship to applicant: _____

Authorization for Financial and Credit Check:

I hereby authorize the Scandinavian Living Center to request and receive financial, asset, and credit information pertaining to me as may be so required to ascertain my ability to pay for services rendered by the Center should I become a member of the Center's community. I also authorize the release of financial records maintained by other entities, including without limitation financial institutions, to the Center for the purposes stated herein. Other than for reporting to financing sources and government agencies the number of community members and their respective income levels, without identifying names, the Center will hold in confidence, and shall not disclose to any person other than its employees, agents and consultants, any such financial information.

I understand and agree that this application is neither a contract, nor a reservation for residency. Nothing contained in this document is legally binding on either me or the Scandinavian Living Center until a Residency Agreement has been signed by all parties involved.

I certify that the information I have given in this Personal Application is true and correct. I understand that any false information or misrepresentation may result in the cancellation of my application or the termination of my Residency Agreement. I further understand that it is my responsibility to notify the Scandinavian Living Center if my financial situation changes.

In addition, I certify that I have been informed by the Scandinavian Living Center of my right to be accompanied by a Legal Representative, Resident Representative or other advisor.

_____ _____
Signature of Applicant Date of Application

If application is filled out by someone other than the applicant:

_____ _____
Signature of person filling out application Date of Application

_____ _____
Printed name of person filling out application Relationship to applicant

Does this person have Durable Power of Attorney to handle your affairs: Yes ____ No____
If yes, please include a complete copy of the POA with this application.