Medical

1. Name of Physician: _____

2. Name of Dentist: _____ Date of last visit: _____

3. Name of Podiatrist: _____

4. Name of Eye Clinic/Ophthalmologist: _____

5. Hospital of choice: _____

6. Are you currently receiving supportive services? Yes _____ No _____ If yes, what kind?

   Meals on Wheels ____ Home health care _____ Medical alert system (Lifeline) _____

   Other services: _____

Please Note:

1. **Prior to or on the day of admission, The Gardens of Hartford will request to make a copy of the following resident information:**

   - **Social Security card**
   - **Medicare card**
   - **Other private insurance card(s)**

2. **In addition, please submit a copy (if applicable) of the following:**

   - **Power of Attorney for Health Care**
   - **Advance Directives**
   - **Living Will**
   - **Power of Attorney for Finance**
   - **Guardianship**

Thank you!

Application for Residency

WLCFS
The Gardens of Hartford™
healing. helping.

Date: _____ Application taken by: _____

Name: _____
(Last name) (First name) (M.I.) (Maiden)

Current address: _____

E-mail (if applicable): _____

Telephone number: _____ Expected admission date: _____

Personal

1. Social Security No: _____
   Medicare No: _____
   Medical Assistance No: _____
   Other Insurance/ID No: _____

2. Date of birth: _____
   (MM/DD/YY)

   Place of birth: _____
   (City) (State) (County)

3. Current marital status: Married ____ Divorced _____ Single _____ Widow(er) _____

   Name of spouse (if living): _____ If deceased, when: _____
   (MM/DD/YY)

4. Are you or your spouse a veteran? Yes _____ No _____ If yes, what Branch: _____

5. Have you applied for Aid & Attendance benefits? Yes _____ No _____

6. Religious affiliation: _____

   Parish/Church:_____

7. Former occupation: _____

8. Highest level of education completed: _____

Authorization to Notify

1. **Power of Attorney for Health Care**

_____

(Name) (Address)

_____

(Telephone) (Relationship)

2. **Alternate for Health Care**

_____

(Name) (Address)

_____

(Telephone) (Relationship)

3. **Power of Attorney for Finance**

_____

(Name) (Address)

_____

(Telephone) (Relationship)

4. **Guardianship**

_____

(Name) (Address)

_____

(Telephone) (Relationship)

5. Please attach a copy of each document that is applicable to the Power of Attorney for Health Care, Finance, or Guardianship.

6. **If the above person(s) cannot be contacted, the following person should be notified:**

_____

(Name) (Address)

_____

(Telephone) (Relationship)

Miscellaneous

1. Who will assist with shopping errands as needed? _____

2. Do you have a burial trust established? Yes _____ No _____

   Name of your funeral home: _____

3. Please list your places of residence for the past five years. (List most recent first.)

_____

(Address) (City) (State) (Zip Code)

_____

(Address) (City) (State) (Zip Code)

_____

(Address) (City) (State) (Zip Code)

_____

(Address) (City) (State) (Zip Code)

_____

(Address) (City) (State) (Zip Code)

4. I certify that the information in this application is true to the best of my ability. The undersigned hereby applies for admission and agrees, if admitted, to comply with all current and future policies and procedures of The Gardens of Hartford.

_____

(Signature of Applicant) (Date)

_____

(Signature of Responsible Party) (Date)

5. Did someone recommend The Gardens of Hartford? Yes _____ No _____

   Family member _____ Friend _____ Staff _____ Physician _____ Other _____ ( )

6. If not, how did you hear about The Gardens of Hartford?

   Yellow Pages _____ Newspaper _____ Senior Resources _____ Radio _____ Other _____

   If other, please specify: _____