Date: _____

Personal Application for Residency

Thank you for your interest in St. Clare-Newport Independent and Assisted Living Apartments. In order to be considered for residency, please complete this application in full. The information contained herein will assist us in determining your ability to live here. If you need assistance in completing this form, please call 401-849-3204 and we will be happy to help.

Completed applications should be returned to:

Attn: Coleen Curran
St. Clare-Newport
309 Spring St.
Newport, RI 02840
Ph 401-849-3204 Fax 401-849-5780
ccurran@stclarenewport.org

PERSONAL HISTORY

Applicant Name_____

Address_____

City _____State _____Zip_____

Telephone_____Email address_____

Rent _____ Own _____ How long at this address? _____

Do you live alone? _____ If not, with whom? _____

Date of Birth _____ Place of Birth_____

Marital Status _____ Former Occupation _____

Religious Preference _____ Parish _____

How did you learn about St. Clare-Newport? _____

Will you be bringing a vehicle to St. Clare-Newport? _____

Name of Contact Person _____ Relationship_____

Address _____

City _____ State _____ Zip _____

Telephone _____ Email _____

Legal Designation if any _____

Emergency Contact Name (if different than above)_____

Address _____

City _____ State _____ Zip_____

Telephone _____ Email_____

Do you have any of the following:

Durable Power of Attorney for Health Care	_____
Health Care Proxy	_____
Living Will	_____
General Power of Attorney	_____
Guardian	_____

If yes to any of the above:

Name: _____

Address _____

City _____ State _____ Zip_____

Phone _____ Email_____

Person to whom correspondence should be addressed:

Name _____

Address _____

City _____State _____Zip _____

Telephone _____Email _____

INSURANCE INFORMATION

Social Security Number: _____

Medicare Number: _____

Part A effective date: _____

Part B effective date: _____

Commercial Insurance: _____

Policy Number : _____

Claims address: _____

_____

_____

Telephone Number _____

Long Term Care Insurance: _____

Policy Number _____

Claims Address _____

_____

MEDICAL INFORMATION

Primary Physician Name : _____Telephone:_____

Address: _____

How would you describe your current state of health?

_____

_____

Do you have medical conditions that require daily monitoring? (ie, insulin, medications, blood pressure, skin condition)?

Describe: _____

Who helps you monitor it now? _____

Please list the medical specialists:

Name _____ Specialty _____Phone _____

Name _____ Specialty _____Phone _____

Name _____ Specialty _____Phone _____

Please list the medications you are taking now:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Describe any assistance you need with medications:

_____

_____

Are you experiencing any memory problems? _____ Explain_____

_____

Do you prepare your own meals? If no, who is? _____

Are you on a special diet? _____ If yes, please describe_____

How much walking do you do? _____

Do you use an assistive device? Cane _____ Walker _____ Other _____

Please help us evaluate your needs by rating your skills in the following areas:

I= Independent M= Moderate Assist T=Total Assist

	Rating	**Comments**
Bathing	_____	_____
Dressing	_____	_____
Walking	_____	_____
Housekeeping	_____	_____
Laundry	_____	_____
Finances	_____	_____
Shopping	_____	_____
Transportation	_____	_____
Safety Awareness	_____	_____

Other: _____

_____

Is incontinence a problem? _____ Explain _____

_____

I authorize my physician(s) to release medical information to St. Clare-Newport for purposed of application and residence.

Signed_____ Date _____

Financial Information

1st Applicant Name _____

Social Security # _____

2nd Applicant Name (if any) _____

Relationship _____

Social Security # _____

	1st Applicant	2nd Applicant
ASSETS		
Equity in Residence	$ _____	$_____
Savings & CD's	$ _____	$ _____
Investments	$ _____	$ _____
Trusts	$ _____	$ _____
Other	$ _____	$ _____
Total	$ _____	$ _____
LIABILITIES		
Mortgage	$ _____	$ _____
Loans	$ _____	$ _____
Other	$ _____	$ _____
Total	$ _____	$ _____
MONTHLY INCOME		
Social Security	$ _____	$ _____
Pension/Annuities	$ _____	$ _____
Interest/dividends	$ _____	$ _____
Trust	$ _____	$ _____
Other	$ _____	$ _____
Total	$ _____	$ _____

Does the death of one applicant alter the income or assets of the other applicant? _____

Explain: _____

Does someone other than you administer your finances? Yes _____ No _____ If yes,

Name _____

Relationship _____

Address _____

Telephone: Day _____ Evening _____

I certify that the information which I have provided in this application is true and correct to the best of my knowledge and belief.

_____ _____
Signature of 1st Applicant Date

_____ _____
Signature of 2nd Applicant Date

_____ _____
Responsible Party, if applicable Date

PHYSICIAN'S MEDICAL QUESTIONNAIRE

*******TIME SENSITIVE DOCUMENT*******

Patient Name: _____

Date of Birth: _____

Physician's Name: _____

Physician's Address: _____

_____

Physician's Telephone: _____

Physician's Fax: _____

I hereby authorize the above named physician to release medical information requested by St. Clare-Newport. This information will be kept confidential and it will be used only for the purpose of determining the most appropriate level of service to meet the above named patient's needs.

_____ _____

Patient's Signature Date

PLEASE COMPLETE QUESTIONNAIRE AND RETURN TO:

ATTENTION: ADMISSIONS

309 SPRING ST.

NEWPORT, RI 02840

PHONE 401-849-3204 FAX 401-849-5780