



Retirement Living Management

Rental Application

Facility Location: _____

Resident Information

CPR _____ Apartment # _____

Resident's Name _____ Move-In Date _____

Former Address _____

Sex [] M [] F Birth Date _____ Age _____ Marital Status _____

Veteran's Status & # _____

Social Security # _____ - _____ - _____ Race _____

Medicare _____ Medicaid _____

Insurance _____ Contract # _____ Policy# _____

Attending Physician _____ Phone # _____

Address _____

Preferred Hospital _____ Phone # _____

Funeral Home _____ Phone # _____

Address _____

Religious Preference _____

Special Equipment _____

Responsible Party

Does Applicant Have A (see attached *Power Of Attorney and Other Advanced Directives* sheet for definitions):

- | | |
|---|---|
| <input type="checkbox"/> Designated Representative | <input type="checkbox"/> Durable Power Of Attorney (DPOA) |
| <input type="checkbox"/> Representative Payee | <input type="checkbox"/> Power Of Attorney for Finances |
| <input type="checkbox"/> Court Appointed Guardian | <input type="checkbox"/> Court Appointed Conservator |
| <input type="checkbox"/> Power Of Attorney for Medical Advanced Directive/Living Will | |

If Yes To Any Of The Above, Provide Information Below and Attached A Copy Of The Appropriate Verification:

Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____

Billing Information

Same As Responsible Party

Send Billing Information To:

Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____

If Interest In Direct Deposit See Administrator

Other Emergency Contacts

1. Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____

2. Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____

3. Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____

Cell Phone _____ Fax _____