The Cascades
An Assisted Living Community

13 Parklawn Drive, Bethel, CT 06801
T: 203.830.7390 – F: 203.797.2996
www.CascadesAssistedLiving.com

APPLICATION FOR RESIDENCY

GENERAL INFORMATION

Applicant _____

Address _____
Street/Unit/Apt No

_____ How long at this address? _____ years
City/State/Zip

Phone (_____) _____ Email _____

Social Security Number _____-_____-_____ Date of Birth _____/_____/_____
Month Date Year

Marital Status: ☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced Sex: ☐ Male ☐ Female

Religion _____ Place of Worship_____

INSURANCE INFORMATION

Medicare Number _____ _____
Policy # Policy # if Medicare HMO

Secondary Insurance _____ _____
Company Name Policy #

LTC Insurance _____ _____
Company Name Policy #

Living Will: ☐ Yes ☐ No (*If yes, please provide a copy)*

Power of Attorney ☐ Yes ☐ No Name _____

Address _____ Phone _____

City/State/Zip _____

Healthcare Agent: ☐ Yes ☐ No Name _____

Address_____ Phone _____

City/State/Zip _____

PERSON TO NOTIFY IN CASE OF EMERGENCY

Name_____

Address _____

City/State/Zip _____

Phone (home) _____ Phone (work) _____

Phone (cell) _____ Email_____

DAILY LIVING ACTIVITES

Can you take care of yourself? ☐Yes ☐No

Task	I can handle this myself	I need some assistance	Comments
Meal Preparation	☐	☐	_____
Dressing/Undressing	☐	☐	_____
Mouth and Skin Care	☐	☐	_____
Shaving and Grooming	☐	☐	_____
Toileting	☐	☐	_____
Walking/Mobility	☐	☐	_____
Transferring	☐	☐	_____
Medication Reminders	☐	☐	_____
Medication Set-up	☐	☐	_____
Taking Medications	☐	☐	_____
Housekeeping/Clothing Management	☐	☐	_____
Transportation	☐	☐	_____
Handling Bills	☐	☐	_____

Do you own an automobile? ☐ Yes ☐ No Make and Year _____

Do you drive regularly? ☐ Yes ☐ No

*How do you spend your time?*_____

_____

What are you interests and/or hobbies? _____

Do you use any devises to assist you in walking or in you daily living activities? ☐ Yes ☐ No

How much walking do you do? _____ *Do you have difficulty with stairs?* ☐Yes ☐ No

Are there any problems or concerns which our staff should be aware of, or any special support you might need to live in our community? _____

Do you require someone (friend, relative, or other person) to live with you at the present time?

☐ Yes ☐ No *If so, who?*_____

Are you considering other housing alternatives? ☐ Yes ☐ No
If so, which ones? _____

MEDICAL INFORMATION

Primary Physician _____

Address _____ Phone _____

City/State/Zip _____

Hospital Affiliation _____

How would you describe your state of health? _____

How often do you see your doctor? _____ *Date of last visit:* _____

Please list most recent dates and nature of major illnesses, hospital stays, operations or therapy treatments (mental illness, nervous condition or physiological disorder):

Date of Service	**Description of Service**	**Facility Providing Service**
_____	_____	_____
_____	_____	_____
_____	_____	_____

What medications do you presently use? Please list both prescriptions, over the counter and non-prescription drugs such as vitamins, laxatives or supplements. Please use additional sheets in necessary.

Medication	**Dosage**	**Over-the-Counter**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to medication? ☐ Yes ☐ No *Please list* _____

Appetite: ☐ Good ☐ Fair ☐ Poor

Do you have any food allergies? ☐ Yes ☐ No *Please list* _____

Do you have any dietary restrictions or special needs? _____

Current Problems/Comments: _____

FINANCIAL INFORMATION

Please complete the following financial information to assist The Cascades in the application process.

Documents such as IRS For 1040, Bank Statements, Trusts and Power of Attorney's may be required.

If applying with spouse, are all assets held jointly? ☐ Yes ☐ No *If no, please list separately.*

Income Sources

The following worksheet is necessary to determine if you financial resources are adequate to cover the monthly living costs at The Cascades (this information will be kept confidential).

Monthly Income:

Social Security Income	$_____ per month
Retirement Income	$_____ per month
Interest & Dividend Income	$_____ per month
Annuity Income	$_____ per month
Life Insurance Benefits	$_____ per month
Support from family	$_____ per month
Rental Income	$_____ per month
Other	$_____ per month
Total Monthly Income	**$_____ per month**

Assets: (*Please attach additional information if necessary).*

	Institution or Description	Account #	Amount
Stocks	_____		$_____
Bonds/Mutual Fund Accounts	_____		$_____
CDs	_____		$_____
Savings Account	_____		$_____
Checking Account	_____		$_____
Life Insurance	_____		$_____
Annuities/Trust	_____		$_____
Real Estate Property	_____		$_____

Total Assets _____ **$**_____

Liabilities

Mortgage (Name of Lender) _____ Amount Owed $_____

If you are currently renting, Name of Landlord/Owner/Manager

Name _____ Monthly Rental Fee $_____

Address_____ Phone _____

City/State/Zip_____

Who will be responsible for payment of bills? ☐ Self ☐ Designee

Name of Designee_____ Relationship_____

Address_____ Phone_____

City/State/Zip_____

Is there any additional information we should be aware of when reviewing you financial resources?

Admission to Bethel Health Care Center Long-Term Care is determined by evaluation and assessment of each individual at the time of the application to Bethel Health Care Center Long-Term Care. Residency at The Cascades Assisted Living does not provide a guaranteed admission to Bethel Health Care Center.

I certify that the information I have given in this Financial Information form is true and correct. I understand that any false statement or misrepresentations or omissions may result in the cancellation of my application or nullification of my Residency Agreement. I authorize The Cascades to conduct a review of my financial status and obtain any information necessary to verify my ability to pay for my residency, including credit reports, etc. I understand that it will be necessary to update this form if there are any material changes in my finances. I further attest that the assets listed here are, in fact, available to pay for my care. I authorize The Cascades to obtain any medical information that may be required to consider my application for residency from any physician, hospital or other medical provider.

Applicant's Signature_____ Date_____

If this form is being completed by someone other than the applicant for residency, please print name of person completing the information, relationship to applicant, and sign on the line below. Attach a copy of Power of Attorney or other documentation authorizing a person to act on the applicant's behalf, if applicable.

Name_____ Relationship_____

Signature____ Date________________________