EVERGREEN
Senior Living
906-774-8943

Evergreen Heights
1820 Mary's Way
Kingsford, MI 49802
(906) 774-8943
Grace@evergreenheightsseniorliving.com

Application for Residency

First Name: _____ Last Name: _____ Date of Birth: _____ SSN: _____

Spouse First Name: _____Spouse Last Name: _____ Date of Birth: _____

Is the applicant or their spouse a Military Veteran? Yes ☐ No ☐ Describe Service History: _____

Today's Date: _____Creed: _____ Pharmacy: _____

Indicate whether the following assistive devices are used by the Applicant:

Wheelchair Yes☐ No☐ Walker Yes ☐ No ☐

Eyeglasses Yes☐ No☐ Hearing Aids Yes ☐ No ☐

Dentures Yes☐ No☐ Cane Yes ☐ No ☐

Other Yes☐ No☐ If yes, please describe: _____

Billing Contact: _____Relation: _____ Billing Address: _____
City: _____ State: ____ Zip: _____ Email: _____ Phone: _____

Emergency Contact: _____ Relation: _____ Street Address: _____
City: _____ State: ____ Zip: _____ Email: _____ Phone: _____

Alternate Contact: _____ Relation: _____ Street Address: _____
City: _____ State: ____ Zip: _____ Email: _____ Phone: _____

Financial Power of Attorney: _____ Street Address: _____
City: _____ State: ____ Zip: _____ Email: _____ Phone: _____

Power of Attorney for Healthcare: _____ Street Address: _____
City: _____ State: ____ Zip: _____ Email: _____ Phone: _____

Patient Advocate or Other Guardian: _____ Street Address: _____
City: _____ State: ____ Zip: _____ Email: _____ Phone: _____

Primary Care Provider: _____ Organization: _____
Date Last Seen: _____Phone: _____ Fax: _____

Dentist: _____ Organization: _____
Date Last Seen: _____Phone: _____ Fax: _____

Eye Doctor: _____ Organization: _____
Date Last Seen: _____Phone: _____ Fax: _____

Other Specialist – Specify _____ Organization: _____
Date Last Seen: _____Phone: _____ Fax: _____

Date of Most Recent Hospitalization or Skilled Nursing Admission: _____
Reason for Admission: _____ Date of Discharge: _____
Name of Facility: _____ City: _____

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List and Describe Previous Surgeries: _____

_____

_____

Does the Applicant have any known food or drug allergies? - Yes ☐ No ☐ Please explain: _____

Does the Applicant use incontinence products? - Yes ☐ No ☐ Please explain: _____

Check 'Yes' below to all that apply:

Asthma	**Yes ☐ No ☐**	Psychological Problems	**Yes ☐ No ☐**
Alcoholism	**Yes ☐ No ☐**	Prone to Aggression	**Yes ☐ No ☐**
Behavioral Problems	Yes ☐ No ☐	Pneumonia Shot	Yes ☐ No ☐ Date: _____
Behavioral Problems	**Yes ☐ No ☐**	Pacemaker	Yes ☐ No ☐
Metal Plates, Screws, or Rods	**Yes ☐ No ☐**	COVID-19 Vaccination	Yes ☐ No ☐ Date: _____
Diabetes	**Yes ☐ No ☐**	Likely to Wander	**Yes ☐ No ☐**
Cancer	**Yes ☐ No ☐**	High Blood Pressure	**Yes ☐ No ☐**
Emphysema	**Yes ☐ No ☐**	Heart Condition	**Yes ☐ No ☐**
Epilepsy	**Yes ☐ No ☐**	Flu Shot	**Yes ☐ No ☐ Date: _____**

Other Medical Condition(s): _____

Please indicate whether the following forms of coverage apply and attach a front & back copy of the insurance card:

Medicare	**Yes ☐ No ☐**	**Vision Insurance**	Yes ☐ No ☐
Prescription Insurance	Yes ☐ No ☐	Dental Insurance	**Yes ☐ No ☐**
Medical Insurance	**Yes ☐ No ☐**	Long Term Care Insurance	**Yes ☐ No ☐**

<u>Advance Directives</u>

Please indicate whether the following advance directives apply and attach a copy:

Do-Not-Resuscitate Order	**Yes ☐ No ☐**	Other	**Yes ☐ No ☐**

<u>Supplemental Submissions</u> The following must be submitted with the application:

1. Have you attached a current Health & Physical (H&P) Report from your Primary Care Provider? **Yes ☐ No ☐**
2. Does the H&P include a current medication list? **Yes ☐ No ☐**
3. Are your insurance cards attached? Yes ☐ No ☐
4. For contacts such as Powers of Attorney – have you attached supporting documentation? **Yes ☐ No ☐**
5. Have you attached Advance Directives, if applicable? **Yes ☐ No ☐**