

ASSISTED LIVING/MEMORY CARE APPLICATION

Thank you for your interest in residency at Hillcrest/Chestnut Grove/Serving Hart Assisted Living and Memory Care. Please complete this application, the information requested on this application is needed to evaluate the applicant's request for residency and will remain confidential.

How did you hear about us? ☐ Website ☐ Word of Mouth ☐ Friend ☐ Other:

Desired Facility: ☐ Chestnut Grove ☐ Hillcrest Adams ☐ Hillcrest Suites ☐ Hillcrest Terrace
☐ Hillcrest Nashwauk ☐ Serving Hart

APPLICANT INFORMATION

Name (First, Middle, Last):

Desired move in date:

Date of Birth:

SSN:

Phone:

Current Address:

City:

State:

Zip Code:

Email Address (resident or point of contact):

Applicant is currently at: ☐ Home ☐ Hospital ☐ Nursing Home ☐ Other: _____

If you own a vehicle and are planning on bring it to the community, complete fields below

VEHICLE INFORMATION

Make/Model of Vehicle:

Vehicle Color:

License Plate #:

Driver's License Number:

SECOND APPLICANT INFORMATION (IF APPLICABLE)

Name (First, Middle, Last):

Desired move in date:

Date of Birth:

SSN:

Phone:

Current Address:

City:

State:

Zip Code:

Email Address (resident or point of contact):

Applicant is currently at: ☐ Home ☐ Hospital ☐ Nursing Home ☐ Other: _____

APPLICANT'S CONTACT INFORMATION

1. Does the Applicant have a Medical Power of Attorney? ☐ Yes ☐ No

If yes, must include copy

Name of Medical Power of Attorney:

Phone:

Current Address:

City:

State:

Zip Code:

Email Address (resident or point of contact):

2. Does the Applicant have a Financial Power of Attorney? ☐ Yes ☐ No

If yes, must include copy

Name of Financial Power of Attorney:

Phone:

Current Address:

City:

State:

Zip Code:

3. Does the Applicant have a Legal Guardian? ☐ Yes ☐ No

If yes, must include copy

Name of Legal Guardian:

Phone:

Current Address:

City:

State:

Zip Code:

4. Does the Applicant have a Designated Representative? ☐ Yes ☐ No

If resident declines to name a Designated Representative, Resident initial here: _____

Name :

Phone:

Relationship to applicant:

Email:

Current Address:

City:

State:

Zip Code:

You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf.

A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if

applicable. This may be the same individual as the legal representative if you choose.

Residents have the right, at any time, to add, remove, or change the name and contact information of the Resident's Designated Representative

If we are unable to reach your designated representative in an emergency situation, please provide an additional contact below:

5. PRIORITY CONTACT #2

Name : Phone:

Relationship to applicant:

Email:

Current Address:

City: State: Zip Code:

Please note in the event of an emergency, we will attempt to notify your designated representative first and if we are unable to reach your designated representative, we will attempt to contact your second contact. It is expected that your designated representative/second contact updates others per your preference.

*****I understand that these authorizations will continue through my residency at the facility if I become such a resident, unless I void such authorizations in writing.***

FIRST APPLICANT INSURANCE INFORMATION

Insurance Carrier:

Group/Policy/ ID Number:

Caseworker Name: Caseworker Phone:

Primary Clinic: Phone:

Primary Physician:

Hospital:

Other Health Care Provider(s)- Name & Clinic:

In order to receive medical assistance are you required to pay a monthly spenddown?

☐ **Yes** ☐ **No** If yes, amount: \$

If Applicant is not covered by medical assistance, has an application been submitted? ☐ **Yes** ☐ **No**

If yes, date of submission: ***Include copy of approval letter if available***

SECOND APPLICANT INSURANCE INFORMATION

Insurance Carrier:

Group/Policy/ ID Number:

Caseworker Name:

Caseworker Phone:

Primary Clinic:

Phone:

Primary Physician:

Hospital:

Other Health Care Provider(s)- Name & Clinic:

In order to receive medical assistance are you required to pay a monthly spenddown?

☐ **Yes** ☐ **No** If yes, amount: \$

If Applicant is not covered by medical assistance, has an application been submitted? ☐ **Yes** ☐ **No**
If yes, date of submission: ***Include copy of approval letter if available***

FIRST APPLICANT FINANCIAL INFORMATION (As of Application Date)**Monthly Income**

Social Security: \$

Pension/Benefits: \$

Other (specify): \$

Current Asset

Checking: \$

Savings: \$

Stocks/bonds/other (specify): \$

Real Estate: \$

Please describe any circumstances which may affect your income, assets or expenses over the next 24 months:

SECOND APPLICANT FINANCIAL INFORMATION (As of Application Date)**Monthly Income**

Social Security: \$

Pension/Benefits: \$

Other (specify): \$

Current Asset

Checking: \$

Savings: \$

Stocks/bonds/other (specify): \$

Real Estate: \$

Please describe any circumstances which may affect your income, assets or expenses over the next 24 months:

APPLICANT QUESTIONNAIRE

1. Have you ever been evicted from a previous residence? ☐ **Yes** ☐ **No**

If yes, when & why?

2. Have you ever been brought to court by a landlord? ☐ **Yes** ☐ **No** If yes, when & why?

3. Have you ever been convicted or plead guilty to a crime other than a minor traffic offense?
☐ **Yes** ☐ **No** If yes, when & why?

4. Do you have the funds available to move in on the date requested? ☐ **Yes** ☐ **No** If no, when?

5. Applicant is a: ☐ **Smoker** ☐ **Non-Smoker**

6. Is the applicant a Veteran? ☐ **Yes** ☐ **No**

7. Is the applicant a spouse of a Veteran? ☐ **Yes** ☐ **No**

Hillcrest/Chestnut Grove/Serving Hart conducts business in accordance with the Federal Fair Housing Law (The Fair Housing Amendments Act), and accepts applications from all persons without regard to

race, color, national origin, gender, creed, disability, sexual orientation, marital status, familial status, alienage or citizenship status, age and/or lawful occupation.

Acknowledgements & Representations

☐ I acknowledge that I have been provided with information regarding the community's participation in certain public assistance programs.

Initials of Applicant: _____

☐ I represent and certify that the information provided in this Application is true and correct to the best of my knowledge as of the date set forth above.

Initials of Applicant: _____

☐ I acknowledge and understand that the community's acceptance and processing of this Application is not an offer of housing and that I should not make plans to move or end my current living situation until I receive such an offer.

Initials of Applicant: _____

☐ I acknowledge and understand that the community will rely on the information contained herein.

Initials of Applicant: _____

Signature:

Applicant Signature

Date

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GENERAL CERTIFICATION

I understand that resident selection is based on a number of factors, primarily on the assessment of- in their best judgment- my ability to be successful in and appropriate for the assisted living environment. Further, I understand that my application can be rejected based on, but not limited to, police records indicating unacceptable or criminal behavior, and medical records indicating violent behaviors

I understand that all payments owed by the Applicant must be made prior to gaining access to the unit I will be renting. Payment for rent and services shall be made monthly, by the 5th of each month thereafter.

I realize that if I do not meet my financial obligation and other stipulations of the Assisted Living Contract, my tenancy may be terminated per our Contract Termination Policy.

Within sixty (60) days of discharge or upon termination of this agreement, the Resident or Legal Representative shall receive a refund, if applicable, of any amount due minus applicable charges through to the effective date of discharge.

I certify that the information given in this application is true to the best of my knowledge. I understand that any false information could be grounds for cancellation of the application or termination of residency after occupancy.

Applicant: _____

Date: _____

Legal Representative: _____

Date: _____

ASSISTED LIVING/MEMORY CARE APPLICATION CHECKLIST

- ☐ Completed Application
- ☐ Contact Information Documentation (if applicable)
- ☐ Medical Power of Attorney (if applicable)
- ☐ Financial Power of Attorney (if applicable)
- ☐ Legal Guardian (if applicable)
- ☐ Copy of Insurance Card(s)
- ☐ Medicare/Medicaid any any other county related Approval Letters (if applicable)
- ☐ Financial Information Documentation
Example: checking/savings account statements, brokerage Statements, Social Security statements, Pension Statements, etc.
- ☐ Copy of most recent asset account statements
- ☐ Signed General Certification and Release of Information form(s)
- ☐ Most recent Health & Physical (Include diagnosis list)
- ☐ Most recent Signed Medication List
- ☐ Most recent Diagnostic Assessment (if applicable)
- ☐ Commitment, Jarvis, Probation Orders (if applicable)

If you are unable to provide the required documentation, please explain:

Thank you for expressing interest in Hillcrest/Chestnut Grove/Serving Hart. We will review your application and determine your eligibility for residency within 10-14 days or less.