



WILEY CREEK COMMUNITY

Application & Medical Information

APPLICATION

We encourage you to complete this application so that we know of your interest and desire to discuss admission options with us. There is no charge or obligation in doing so. All information listed below is confidential and will not be used by the Wiley Creek Community staff unless written permission is given by the applicant.

Applicant #1

Name _____

Address _____

City/State/Zip _____

Phone _____

SS # _____

Birthdate _____

Applicant #2

Name _____

Address _____

City/State/Zip _____

Phone _____

SS # _____

Birthdate _____

List two contacts, preferably children, brothers or sisters

Name _____

Name _____

Relationship _____

Relationship _____

Address _____

Address _____

City/State/Zip _____

City/State/Zip _____

Phone _____

Phone _____

OTHER INFORMATION

Interested in Assisted Living or Independent Living

Size and location of apartment you prefer:

Studio 1-Bdrm 2-Bdrm 3-Bdrm View of the woods Doesn't matter

When would you like to move? Immediately Within 6 months Other

Private Pay Medicaid # _____



MEDICAL INFORMATION

Please complete for each person applying for admission to the Assisted Living Lodge

Applicant #1

Name _____

Primary Physician _____

Diagnosis or Major Illness _____

Medications You Take _____

Medication Assistance Needed. *Please check one.*

- None, gives self medication
- Needs supervision or reminders for self medication
- Medications administered by another person

Diabetes Yes No
If yes, Pills Injections

Dressing: Independent Needs Assist
Bathing: Independent Needs Assist
Toileting: Independent Needs Assist
Walking: Independent Needs Assist

Needs: Wheelchair Walker

- History of mental illness or psychotic behavior
- Short term memory loss
- Disoriented to time or place
- Confused
- Wanders, gets lost frequently
- Agitation or episodes of anger/aggression
- Depression, isolation
- None of the above

Do you anticipate any major changes in your health status in the next year? If yes, please explain.

Applicant #2

Name _____

Primary Physician _____

Diagnosis or Major Illness _____

Medications You Take _____

Medication Assistance Needed. *Please check one.*

- None, gives self medication
- Needs supervision or reminders for self medication
- Medications administered by another person

Diabetes Yes No
If yes, Pills Injections

Dressing: Independent Needs Assist
Bathing: Independent Needs Assist
Toileting: Independent Needs Assist
Walking: Independent Needs Assist

Needs: Wheelchair Walker

- History of mental illness or psychotic behavior
- Short term memory loss
- Disoriented to time or place
- Confused
- Wanders, gets lost frequently
- Agitation or episodes of anger/aggression
- Depression, isolation
- None of the above

Do you anticipate any major changes in your health status in the next year? If yes, please explain.

FINANCIAL STATEMENT OF APPLICANT

ASSETS:		LIABILITIES:	
Cash (Checking & Savings)	_____	Notes Payable	_____
Stocks & Securities	_____	Bank Charge Cards	_____
Life Insurance	_____	Other	_____
CDs, Certificates, etc.	_____	Real Estate Payables	_____
Government Bonds	_____	Other Liabilities: <i>(Describe)</i>	_____
Other Income	_____		_____
Home Value	_____		_____
Other Real Estate <i>(Value Less Unpaid Balance)</i>	_____		_____
Other	_____		_____
Total Assets:	\$ _____	Total Liabilities:	\$ _____

INCOME:		EXPENSES:	
Social Security <i>(monthly)</i> Applicant #1	_____	Average monthly medical bills	_____
Applicant #2	_____	Average monthly cost of prescriptions	_____
Pension / Retirement	_____	Installment Notes	_____
Annuities	_____	Other <i>(describe)</i>	_____
Life Insurance	_____		_____
Dividends	_____		_____
Rents	_____		_____
Other <i>(describe)</i>	_____		_____
Total Monthly Income:	\$ _____	Average Monthly Expenses:	\$ _____

Name (Please print) _____
Date

Signature