



THE TERRACES AT SKYLINE

APPLICATION FOR ASSISTED LIVING RESIDENCY

FOR USE BY THE TERRACES at SKYLINE

MS AL Start Date: _____

Apt # 1342 Style: 10A

Please complete the following form and submit with your Medical Information form from your Physician.

Please print.

RESIDENT NAME

Last _____ First _____ MI _____

Household- Composition:

Single Married Widowed Other (specify) _____

Current Address:

Street _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Fax _____

Gender M F Date of Birth _____ Soc. Sec. No. _____

E-mail Address _____

Medicare # _____ A / B

Supplemental Insurance _____ Suppl. Ins. # _____

Do you have Advance Directives to Physicians? Yes No If Yes, please provide a copy for our files.

Hospital Preference _____
Mortuary _____

THE TERRACES will send monthly billing statements to Resident unless otherwise specified here:

Name		
Address		
Home Phone	Work Phone	Cell Phone
Relationship		

OPTIONS

Preferred title designation (circle):

Mr. Ms. Mrs. Rev. Dr. Other: _____

Would you like to be listed in the Skyline at First Hill phone directory? ___ Yes ___ No

Name _____ Address ___ Yes ___ No

How would you like your name(s) to appear on your door? (John & Mary Doe / The Does, etc.)

Will you be bringing a pet or pets?

___ Yes ___ No ___ # of Pets ___ Cat ___ Bird

CONTACT INFORMATION:
PLEASE PRINT.

Durable Power of Attorney for Healthcare. Please provide a copy.

Name		Relationship
Address		
Home Phone	Work Phone	Cell Phone

Durable Power of Attorney for Finance: Please provide a copy.

Name		Relationship
Address		
Home Phone	Work Phone	Cell Phone

Additional family or other persons to contact in case of Emergency:

Name		Relationship
Address		
Home Phone	Work Phone	Cell Phone

Name		Relationship
Address		
Home Phone	Work Phone	Cell Phone

Name		Relationship
Address		
Home Phone	Work Phone	Cell Phone

Name		Relationship
Address		
Home Phone	Work Phone	Cell Phone

CURRENT FINANCIAL INFORMATION:

PLEASE PRINT.

Name(s) _____

MONTHLY INCOME

<u>Description</u>	<u>Amount</u>	<u>Documentation Attached</u>
Social Security	\$	
Pension	\$	
Trust	\$	
Interest/dividends	\$	
Annuity	\$	
Salary/wages	\$	
Other	\$	
<u>TOTAL</u>	\$	

ASSETS

<u>Description</u>	<u>Current Market Value</u>	<u>Documentation Attached</u>
Checking Account	\$	
Savings Account	\$	
Stocks & Bonds	\$	
Certificates of Deposit	\$	
Trust account Balance	\$	
Life Insurance – Cash Balance	\$	
Annuity – Cash Balance	\$	
Notes Receivable	\$	
Real Estate	\$	
Due from relatives	\$	
Other Assets	\$	
<u>TOTAL</u>	\$	

LIABILITIES

<u>Description</u>	<u>Amount</u>	<u>Documentation Attached</u>				
Mortgages	\$	<table border="1"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>				
Other	\$					
Due to relatives	\$					
<u>TOTAL</u>	\$					

Life Insurance, Long Term Care Insurance and Health Insurance you carry:

Type of Policy	Company	Amount	Beneficiary

Does your pension/retirement plan provide cost of living increases?

Yes No

List any additional financial information which you feel should be considered.

HEALTH AND MEDICAL BACKGROUND

Please complete a separate form for a second resident.

Resident 1 - NAME _____

PRESENT DIAGNOSES _____

ALLERGIES OR SENSITIVITIES (to medicines, foods, etc. If none, please so indicate)

PRESENT MEDICATION OR VITAMINS (Attach additional pages if needed.)
List all prescription and non-prescription (over the counter) medications, including dosage strength and how often taken.

MEDICATION	STRENGTH	FREQUENCY
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WHEN WAS YOUR LATEST (Month and Year)

Physical Exam _____ Physician _____

Eye Exam (Glaucoma Check) _____ Physician _____

Chest X-Ray _____ TB Skin Test _____ Ever Positive? ___ Yes ___ No

LIST ANY MAJOR SURGERIES _____

ANY OTHER SERIOUS INJURIES OR ILLNESSES? (List type with month and year)

LIFESTYLE AND HEALTH PRACTICES

DO YOU EXERCISE REGULARLY? ___ YES ___ NO
What kind? _____ How many days per week? _____

DO YOU REQUIRE PHYSICIAN PRESCRIBED SPECIAL DIET? ___ YES ___ NO
What kind? _____

Do you need special assistance with the following tasks?

<u>Yes</u>	<u>No</u>	<u>Assistance</u>	<u>Description</u>
_____	_____	Medications	_____
_____	_____	Transfer from sitting surfaces	_____
_____	_____	Walking	_____
_____	_____	Stairs	_____
_____	_____	Toileting	_____
_____	_____	Bathing	_____
_____	_____	Dressing	_____
_____	_____	Grooming	_____
_____	_____	Housework	_____
_____	_____	Laundry	_____
_____	_____	Shopping	_____
_____	_____	Meal Preparation	_____
_____	_____	Writing	_____
_____	_____	Reading	_____
_____	_____	Telephone	_____
_____	_____	Managing Finances	_____
_____	_____	Motorized Scooter	_____
_____	_____	Wheelchair	_____
_____	_____	Walker	_____
_____	_____	Cane	_____
_____	_____	Oxygen	_____
_____	_____	Hearing Aid	_____
_____	_____	Colostomy	_____
_____	_____	Other	_____

Please list any other activity limitations:

NOTICE TO ALL APPLICANTS: Presbyterian Retirement Communities Northwest, a Washington not-for-profit corporation which owns and operates Park Shore, Exeter House, and FH, LLC D/B/A The Terraces at Skyline complies with all federal, state and local human rights laws.

If residency is not established within one (1) month of the approval of this application, updated medical and financial information may be required.

I HEREBY DECLARE THAT ALL STATEMENTS MADE HEREIN ARE TRUE AND COMPLETE ACCORDING TO MY BEST KNOWLEDGE AND BELIEF.

APPLICANT(1) _____

DATE _____

THE TERRACES at SKYLINE
MEDICAL BACKGROUND AND INFORMATION

APPLICANT NAME: _____ MALE ___ FEMALE

ADDRESS _____

DATE OF BIRTH _____

RELEASE OF INFORMATION

I authorize my Physician to release the following information concerning my present state of health to THE TERRACES at SKYLINE ("THE TERRACES"). I understand that this information will be reviewed by designated agents of The Terraces and will be kept on file in THE TERRACES offices for use in the event of a medical or other emergency. I also understand that this information will be used by THE TERRACES to assist in determining the care and services I need during my residency at THE TERRACES, and to assist THE TERRACES in placing me in a living situation that would not adversely affect my health or safety or the health or safety of other residents at THE TERRACES.

APPLICANT SIGNATURE _____ DATE _____

THE ATTACHED HISTORY AND PHYSICAL IS TO BE COMPLETED BY THE PHYSICIAN:

PLEASE RETURN TO:
Marketing Office
THE TERRACES at SKYLINE
715 9th AVE
SEATTLE, WA 98104
FAX (206) 407-1722

