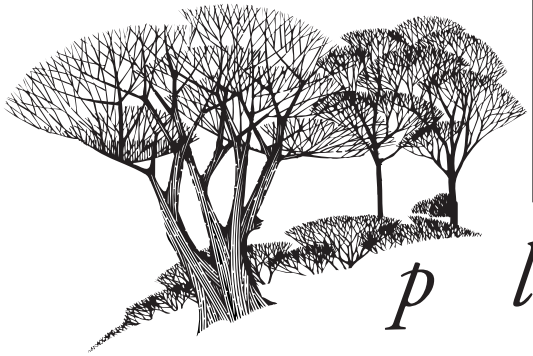

Oak Park® place

Application for Occupancy

I am applying for: (mark one) _____ Independent Living

_____ Assisted Living

_____ Skilled Nursing

Confidential

718 Jupiter Drive
Madison, WI 53718-2952
Phone: 608-663-8600
Fax: 608-251-2868
www.oakparkplace.com

Date Received:

_____

PERSONAL HISTORY

Name _____ Age_____

Birthday_____ Phone (including area code) _____

Address _____

City, State, Zip Code _____

Years at this address _____

Social Security # _____ Medicare # _____

Medicaid # _____

Supplemental Insurance (Company Name) _____

Supplemental Insurance (Number) _____

Prescription Insurance (Company) _____ # _____

Check one ❑ Married ❑ Widowed ❑ Divorced ❑ Single

What are you present living arrangements? ❑ Own Home ❑ Rent ❑ Other

Choice of Accommodations:

Independent Living	Assisted Living	Assisted Memory Care	Skilled Nursing
The Arbors	*The Grove*	❑ Studio ❑ 1 Bedroom	❑ Private ❑ Semi-Private ❑ Memory Care
❑ Studio ❑ 1 Bedroom ❑ 2 Bedroom	❑ Studio ❑ 1 Bedroom ❑ 2 Bedroom		

Who should we contact in case of emergency:

Name _____ Home Telephone # _____
Address _____ Work Telephone# _____
City, State, Zip Code _____ Cell Phone # _____
Relationship _____

Name _____ Home Telephone # _____
Address _____ Work Telephone# _____
City, State, Zip Code _____ Cell Phone # _____
Relationship _____

Name _____ Home Telephone # _____
Address _____ Work Telephone# _____
City, State, Zip Code _____ Cell Phone # _____
Relationship _____

Monthly rental statement/bill should be sent to:

Name _____
Address _____
City, State, Zip Code _____
Telephone : _____

Do you have someone designated as Financial Power of Attorney or Guardian?

Name _____
Address _____
City, State, Zip Code _____
Telephone # _____

Please list the clubs and organizations, church-related or social, to which you belong or have belonged. How do you spend your free time? Include hobbies and interests.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Religion _____
Clergy _____
Church/Temple _____
Telephone # _____

HEALTH HISTORY

Your physicians:

1. Name _____
   Clinic _____ Telephone # _____

2. Name _____
   Clinic _____ Telephone # _____

Do you have someone designated as the Health Care Power of Attorney or Guardian?

Name _____ Home Telephone # _____
Address _____ Work Telephone# _____
City, State, Zip Code _____ Cell Phone # _____
Relationship _____

Do you have a living will? ❑ Yes ❑ No

Funeral Home _____
Address _____ Telephone # _____

Rate your general health ❑ Good ❑ Average ❑ Fair ❑ Poor

Current health problems _____
_____
_____
_____
_____

Describe surgical operations, serious illness and hospitalization, including admission to a nursing home during the past 12 months _____
_____
_____
_____
_____

List the medications you are taking (including non-prescription drugs)
_____
_____
_____
_____

Describe any allergies _____
_____
_____

Do you have any special diet requirements? _____
_____
_____
_____
_____
_____

Have you ever had the following?

Vision Problems	Yes_____	Kidney Disease	Yes_____
Lung Disease	Yes_____	Cancer	Yes_____
Drug Dependency	Yes_____	Digestion Problems	Yes_____
Stroke	Yes_____	Arthritis	Yes_____
Heart Trouble	Yes_____	Hearing Problems	Yes_____
Alcohol Dependency	Yes_____	Memory Loss	Yes_____
Diabetes	Yes_____	Mental Illness	Yes_____
-with Insulin	Yes_____		

Do you use?

Cane	Yes_____	Walker	Yes_____
Glasses	Yes_____	Wheelchair	Yes_____
Dentures	Yes_____	Prosthetic Device	Yes_____
Hearing Aid(s)	Yes_____		

Do you require assistance with

Dressing	Yes_____	Grocery Shopping	Yes_____
Bathing	Yes_____	Meal Preparation	Yes_____
Grooming	Yes_____	Transportation	Yes_____
Housekeeping	Yes_____	Medication Set-Up	Yes_____

Are you currently receiving services from a Community Agency or private party? If yes, from whom and how often? _____
_____
_____
_____
_____
_____

FINANCIAL STATEMENT

FIXED MONTHLY INCOME

Social Security $_____

Pensions (Pleases indicate source, i.e., government, private sources) $_____

Interest from stocks and bonds $_____

Other $_____

TOTAL FIXED MONTHLY INCOME $_____

ASSETS

Stocks, Bonds, Mutual Funds $_____

Cash (Savings/Checking) $_____

Real Estate $_____

Cash Value of Life Insurance $_____

Other $_____

TOTAL ASSETS $_____

LIABILITIES

Mortgage $_____

Loans $_____

Other $_____

TOTAL LIABILITIES $_____

I declare that the information contained herein is true and complete to the best of my knowledge, and that any misrepresentation, concealment or omission may cause the agreement to be voided at the option of Oak Park Place. I understand that Oak Park Place may contact my doctor for any other information regarding my medical history. I further understand that this information is confidential and will be used to process my application and will be relied upon in determining my eligibility for residency.

_____ _____

Signature of Applicant Date

For Application to Oak Park Place

❑ $50.00 Application Fee Enclosed.

Application fee is not refundable.