Generations Senior Living of Berea
New Resident Information

Resident (Please Print): _____

DEMOGRAPHIC & PERSONAL:

Present Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Other: _____

Date of Birth: _____ Age: _____ Social Security #: _____

Gender: ☐Male ☐Female Race: ☐Caucasian ☐African American ☐Hispanic ☐Native American ☐Asian

Former Occupation: _____ Religion: _____

MARITAL STATUS:

☐Single ☐Widowed ☐Separated ☐Divorced ☐Married Spouses' Name: _____

Parking an automobile in the facility parking lot? ☐YES ☐NO

Make: _____ Model: _____ Year: _____

Color: _____ License Plate #: _____

LEGAL DOCUMENTS:

Please indicate if you have any of the following documents

General Power of Attorney ☐Yes ☐No If yes, who? _____

Legal Guardian ☐Yes ☐No If yes, who? _____

Durable Power of Attorney For Healthcare ☐Yes ☐No If yes, who? _____

Ohio DNRCC ☐Yes ☐No

Ohio DNRCC-ARREST ☐Yes ☐No

Living Will/Trust ☐Yes ☐No

Please Note: If you have indicated yes to having any of the above documents, you must provide a copy to the facility on or before move-in. Please speak to the Executive Director regarding additional information about these documents and their purpose.

FINANCES:

Does someone else assist you with your finances? ☐Yes ☐No If yes, who? _____

Mail Monthly Statement to: ☐Resident ☐Other

Name: _____ Address: _____

City: _____ State: _____ Zip: _____

FUNERAL ARRANGEMENTS:

Do you have pre-planned funeral arrangements? ☐Yes ☐No If yes, who? _____

Name of Funeral Home: _____

Address: _____ City/State: _____ Zip: _____

Contact Person: _____ Phone: _____

SIGNIFICANT OTHER (FAMILY, FRIEND AND JOINT ACCOUNT HOLDER):

Emergency Contact Preference Order:

(#1 Contact Person)

Name _____ Relationship _____

Street Address _____

City _____ State _____ Zip_____

Phone (Home) _____ (Work) _____ (Cellular) _____

E-mail _____

(#2 Contact Person)

Name _____ Relationship _____

Street Address _____

City _____ State _____ Zip_____

Phone (Home) _____ (Work) _____ (Cellular) _____

E-mail _____

(#3 Contact Person)

Name _____ Relationship _____

Street Address _____

City _____ State _____ Zip_____

Phone (Home) _____ (Work) _____ (Cellular) _____

E-mail _____

LEGAL RELATIONSHIP (Attorney, Legal Guardian, P.O.A)

Name _____ Relationship _____

Street Address _____

City _____ State _____ Zip_____

Phone (Home) _____ (Work) _____ (Cellular) _____

E-mail _____

Name _____ Relationship _____

Street Address _____

City _____ State _____ Zip_____

Phone (Home) _____ (Work) _____ (Cellular) _____

E-mail _____

MEDICAL INFORMATION:

Medicare #: _____ Part B: ☐Yes ☐No

Medicare #: _____ Part D: ☐Yes ☐No

Name and phone number of Part D Provider: _____

Medicaid: ☐No ☐Yes #: _____

HEALTH INSURANCE COMPANY: **Include a copy of the front and back of all health insurance cards!**

Primary: _____ Policy Holder: _____

Policy or Group Number: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

HEALTH INSURANCE COMPANY CONTINUED:

Secondary: _____ Policy Holder: _____

Policy or Group Number: _____ Phone: _____

Street Address: _____

City: _____ State: _____ Zip: _____

DOCTORS (Primary Care Physician, Podiatrist, Optometrist, Etc.)

Name: _____ Type: _____

Hospital: _____ Phone: _____

Address: _____ City: _____

Office Address: _____ Phone: _____

Name: _____ Type: _____

Hospital: _____ Phone: _____

Address: _____ City: _____

Office Address: _____ Phone: _____

Name: _____ Type: _____

Hospital: _____ Phone: _____

Address: _____ City: _____

Office Address: _____ Phone: _____

FULL DISCLOSURE

The information provided by me in the entirety of this application packet and admissions procedure is true, full and accurate. Should this information require changes in anyway, I (or my responsible party) will notify the Executive Director.

_____ _____

Resident Date

_____ _____

Responsible Party Date