

## Residency Application

Thank you for your interest in Three Crowns Park. Please complete this application in full. The information requested will help us determine how we can best meet your needs. Please do not hesitate to call us at (847) 328-8700 if you need assistance completing this form. Please return the completed application to Three Crowns Park, 2323 McDaniel Ave. Ste. TCP, Evanston, Illinois 60201-2570 or fax it to Attn: Admissions at (847) 328-8274.

Applicant Name \_\_\_\_\_

Social Security Number \_\_\_\_\_ Medicare Number \_\_\_\_\_

Supplemental Insurance \_\_\_\_\_ Group Number \_\_\_\_\_

Current Address \_\_\_\_\_ Rent \_\_\_\_ Own \_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ How long at this address? \_\_\_\_\_

Date of Birth \_\_\_\_\_ Birth Place \_\_\_\_\_

Marital Status \_\_\_\_\_ Husband's or wife's name \_\_\_\_\_

In the event of illness or emergency, notify the following person(s).

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number(s): Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number(s): Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Address \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone Number(s): Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

Address \_\_\_\_\_

**II. HOUSING**

Do you live alone? yes \_\_\_\_ no \_\_\_\_ If no, with whom do you live? \_\_\_\_\_

Is there any special support or assistance you will need? \_\_\_\_\_

\_\_\_\_\_

Are you considering other alternatives? If so, what? \_\_\_\_\_

\_\_\_\_\_

How did you hear about Three Crowns Park? \_\_\_\_\_

\_\_\_\_\_

**III. MEDICAL INFORMATION**

Primary Physician's Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Physician's Hospital Affiliation \_\_\_\_\_

Describe your present state of health \_\_\_\_\_

\_\_\_\_\_

Do you have a health condition that requires regular, daily attention or monitoring? (e.g. checking response to medications, blood pressure, checking condition of skin, etc.)

yes \_\_\_\_ no \_\_\_\_ If yes, for what? \_\_\_\_\_

Who monitors it now? \_\_\_\_\_

Do you see a Specialist? yes \_\_\_\_ no \_\_\_\_ Name \_\_\_\_\_

Specialty \_\_\_\_\_ Why? \_\_\_\_\_

Name of Dentist

Phone \_\_\_\_\_

Address

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Are you on medication at the present time? yes \_\_\_\_\_ no \_\_\_\_\_

Please \_\_\_\_\_ list \_\_\_\_\_ medication(s)

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Is there a history of mental illness? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, please explain:

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Do you prepare your own meals? yes \_\_\_\_\_ no \_\_\_\_\_ If no, who does? \_\_\_\_\_

Are you on a special diet? yes \_\_\_\_\_ no \_\_\_\_\_ If yes, please explain \_\_\_\_\_

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How \_\_\_\_\_ much \_\_\_\_\_ walking \_\_\_\_\_ do \_\_\_\_\_ you  
do? \_\_\_\_\_

Do you have difficulty with stairs? yes \_\_\_\_\_ no \_\_\_\_\_

Please help us evaluate your needs by rating your skills in the following areas

	Independent	Need Moderate Assistance	Need Total Assistance	Comments
Bathing				
Dressing				
Walking				
Housekeeping				
Laundry				
Shopping				
Toileting				
Eating				

I understand and agree that the foregoing application is not a contract or reservation for residence. Nothing contained herein is binding on either party until a Residence Agreement has been signed.

I certify that the information which I have provided in this application is true and correct to the best of my knowledge and belief.

Revised 8/12/2008

Signature \_\_\_\_\_ Date \_\_\_\_\_ of  
Applicant \_\_\_\_\_

Signature of Person Completing Form if Not Applicant:

\_\_\_\_\_ Date \_\_\_\_\_