

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

Are you on medication at the present time? yes _____ no _____

Please _____ list _____ medication(s)

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 _____