CHENEY ASSISTED LIVING

APPLICATION FOR ADMISSION

All Programs And Services Shall Be Made Available Without Regard To Race, Color, Religion, National Origin, Age, Disability, Marital Status, Veteran Status, Sex, Or Any Other Characteristic Protected By Law.

PERSONAL INFORMATION

Applicant's Name _____ SS#: _____

Address _____ Telephone ( )_____

City _____ State _____ Zip _____

Date of Birth ___/___/___ Age ____ Present Housing (apt, private home, condo, etc.) _____
If Applicable:
Spouse's Name _____Spouse DOB ___/___/____ Age ____ SS# _____

POWER OF ATTORNEY/GUARDIAN AND FAMILY INFORMATION

Power of Attorney/Guardian (circle one) Time Power of Attorney/Guardian Becomes Effective _____

_____ Age ____ Relationship _____ Spouse's Name _____

Address _____
Street City State Zip
Occupation/Employer
_____ Work Phone ( )_____ Home Phone ( )_____

Nearest Relative/Friend (circle one)
_____ Age ____ Relationship _____ Spouse's Name _____

Address _____
Street City State Zip
Occupation/Employer
_____ Work Phone ( )_____ Home Phone ( )_____

PHYSICIAN INFORMATION

Physician _____ Telephone ( )_____

Address _____
Street City State Zip

HOUSING PREFERENCE FOR ASSISTED LIVING

Housing Preference:

- ☐ Unit A/Studio 366 sq. ft.
- ☐ Unit B/1 Bedroom 428 sq. ft.
- ☐ Unit C/1 Bedroom 481 sq. ft.
- ☐ Unit D/1 Bedroom 573 sq. ft.

ACKNOWLEDGMENT STATEMENT

I acknowledge that the information in this application is correct, and I understand that my Physician may be contacted regarding my ability to live in an Assisted Living facility. I understand that a Deposit Fee of $ 1000.00 will be required as a security deposit and to hold the unit pending move in. The fee will be refunded in full or in part based on facility policy.

Applicant Signature: _____ Date: ____/____/____

Power of Attorney/Guardian: _____ Date: ____/____/____

CHENEY ASSISTED LIVING

FINANCIAL STATEMENT

All Programs and Services Shall Be Made Available Without Regard to Race, Color, Religion, National Origin, Age, Disability, Marital Status, Veteran Status, Sex, Or Any Other Characteristic Protected By Law.

Applicant's Name _____

Spouse's Name _____

Joint Statement? ☐ Yes ☐ No Application for unit # _____

1. FINANCIAL STATEMENT Note: It is not necessary to provide the details of your total estate. We do need sufficient information to assure Cheney Assisted Living that your monthly income is adequate to cover the Monthly Service Charge and provide for other ordinary expenses.

I have the following sources of income and/or assets monthly

	Value	Monthly Income
Social Security Payments.....		$ _____
Life Insurance Annuity.....		$ _____
Pension or Retirement Income.....		$ _____
Interest or Dividends.....		$ _____
Cash - Savings.....	$ _____	$ _____
Cash - Checking.....	$ _____	$ _____
Stocks and Bonds and Securities.....	$ _____	$ _____
Notes or Contracts.....	$ _____	$ _____
Rental Property (describe) _ _____ _____	$ _____	$ _____
Other Real Estate (describe) _____ _____	$ _____	$ _____
Total	$ _____	$ _____

2. Name and address of my bank _____

_____

3. Will any relative contribute toward your support? _____

If so - Name and Address _____

Details of Support _____

4. Life Insurance Information: Amount _____ Company _____

Beneficiary: _____

5. If your resources should become insufficient, would you be willing to apply for State Assistance? _____

The foregoing statements are true and complete. If admitted as a resident of Cheney Assisted Living, I agree to be governed by the rules and regulations now or hereafter to be established by the Board of Directors or Administrator of the Cheney Care Center. I understand that any misstatement will subject me to liability or removal even after admission.

Signature _____ Date _____

Cheney Assisted Living criteria for admission:

1. Be independently mobile - able to ambulate or propel self without assistance and independently exit the building (assistive devices may be used).
2. Able to manage his/her activities of daily living, transfer, and manage bowel and bladder care with adequate hygiene and without assistance.
3. Having a colostomy, ileostomy, urinary catheter, oxygen or other medical need, including medication, must be capable of caring for that device by him/herself or with assistance available from a home health agency.
4. Exhibiting behavior problems disturbing to other residents is inappropriate for this facility. If the behavior problem(s) can be controlled because of behavior management, medication, family, home health agency, or mental health intervention, the resident may be accepted for admission.
5. Meet appropriate score on the mental and functional assessments conducted by a multi-disciplinary team.

**If the resident's needs cannot be met, the resident will not qualify for residency.

Cheney Assisted Living criteria for discharge:

1. Incontinence, if the resident cannot or will not participate in the management of the problem.
2. Immobility.
3. An ongoing condition requiring a one-person transfer.
4. Ongoing skilled nursing interventions needed 24 hours/day for an extended period. (In the event of a temporary illness wherein a licensed nurse was needed for treatment, I understand I can arrange privately for Home Health Services to attend to temporary needs).
5. Symptoms of dementia that exceed manageability.

Cheney Assisted Living Medicaid

Cheney Assisted Living reserves our studio apartments for individuals with Medicaid. If a resident who admits to Cheney Assisted Living as a private pay resident exhausts their funds and converts to Medicaid, they will be automatically placed on a waiting list to move to the next available studio apartment.

I _____ or my legal representative _____ have read the above criteria for admission and discharge to/from the Cheney Assisted Living facility and I agree to comply with the terms and conditions set forth here and in the Assisted Living Agreement.

_____ _____

Signature Date

Admission Worksheet

Financial Information

Primary Insurance (Medicare, Medicaid, HMO, Private, VA Contract):_____

Secondary Insurance (if applicable): _____

Medicaid # (if applicable):_____

Medicare # (if applicable):_____

Funeral Home Preference (Optional)

_____

COVID Vaccination Status (Optional, not required for admission)

Date _____ Brand _____ Date _____ Brand _____

Date _____ Brand _____ Date _____ Brand _____

Care Needs

Current PCP:_____ Phone: _____

Current Weight:_____ Smokes (Please circle one): Yes No

Diagnosis/Symptoms:_____

Mobility:_____

Mental Status:_____

Toileting:_____

Feeding:_____

Diet:_____

Special Treatments:_____

Allergies:_____

Current Medications:_____

_____

_____

_____