Haven Hills
Resident Application and Information

Name ____ Birthdate ____________________

Place of Birth _______________________________________ Age _______________

Social Security Number ____

Home Address ____

City _________________________________ State ___________ Zip ______________

Current Residence ____

Phone (   ) ____

Marital Status _____________________ Spouse's Name _____________________________

If spouse deceased, date of death ____

Number of Children _____________ Number of Grandchildren _____________________

Names of Children

____

____

____

Religion __________________________ Church ___________________________________

Clergyman's Name ______________________________ Phone (   ) _________________

Former Occupation _________________________________ Year Retired_______________

Highest Level of Education ________________________ Where _______________________

Clubs of Fraternal Groups ____

____

Do you have a Power of Attorney ________________ Guardian _________________________

Name ____

Address ____

City _______________________________ State ________________ Zip ________________

Home Phone (   ) _______________________ Work Phone (   ) __________________

Who to contact in case of emergency:

Name ________________________________Phone Home (   ) ______________________

Relationship __________________________ Phone Work (   ) ______________________

Desired admission date ________________ Respite ____________ Long term ___________

Method of payment   Self ___________ Other ___________

Send invoice to:

Name ____

Address ____

City ___________________________________ State ___________ Zip ________________

List any special housing needs you may have:

____

____

____

Health Information

Do you have a Healthcare Power of Attorney? Yes __________ No __________

Name ___________________________________ Phone (   ) __________________

Condition at this time:

____

____

____

Primary Physician ____

Phone (   ) _______________________________

Address ___________________________________

City ________________________________ State ___________ Zip ______________

Other Physicians _____________________________ Phone (   ) ________________

Dentist _______________________________ Phone (   ) _____________________

Address ___________________________________

City ________________________________ State ___________ Zip ______________

All residents are required to have a medical examination before admittance. The examination must include a TB screening. In addition, a yearly examination is required of each resident and documentation must be kept on file at the residence, per State of WI guidelines. A form will be provided for your physician, which must be returned for your resident file.

Application Date ________________ Prepared By ________________________________

The information above is true and accurate to the best of my knowledge. It is understood that this information will be used in determining eligibility for residency.

Signed ____ Date __________________

Resident or responsible party