Resident Application

Fairhaven

Christian Retirement Center

3470 N Alpine Rd
Rockford, IL 61114
815-877-1441
www.fairhaven.cc

I declare that
the information on this application is complete and accurate. I also agree with the **Criteria for self care** found on page 4 (health information section) which will become part of my permanent record.

Name (printed) ______________________

Signature ______________________ Date _____

This information will be reviewed by the admittance committee and you will be advised of its acceptance. If you go on our waiting list, health and financial information may need to be updated when we have suitable accommodations and you are ready to move in.

Last Name ____________________ First Name ____________ MI ____

Address ________________________________ City ___________________

State _____ Zip _________ Phone _____________ Cell ______________

Email address ___________________

Date of Birth _______________ Age _____ Male ____ Female ____

Family & Personal History

Place of Birth ___________________

Parent's names ______________________ Mother's Maiden Name ________________________________

Marital Status

Single _____ Married ______ Widowed ________ Divorced ______

Spouse's name _________________ Anniversary Date _________

Number of Siblings _____ Children _____ Grand Children _____
Great Grandchildren ______

Closest relatives or friends concerned with your well being
Name __________________________________ Relationship __________
Phone ____________ Address ____________________________________
Cell Phone _______________

Name __________________________________ Relationship __________
Phone ____________ Address ____________________________________
Cell Phone _______________

Name __________________________________ Relationship __________
Phone ____________ Address ____________________________________
Cell Phone _______________

Education and training ____

Previous occupation ______________________ Employer _____________
Military service ______ branch ____________________________

Church & spiritual relationships

Church ______________________________ Pastor _______________

Address _________________________________ Phone ____________

Years of membership __________

Services performed for your church

____

Fairhaven Christian Retirement Center is an affiliate of the Great Lakes District of the Evangelical Free Church of America. Would you be able to be comfortable in this Christian environment? _________
Comments ____

Social Interests

Where have you traveled

____

Names of clubs and organizations you are or have been affiliated with

____

Hobbies and interests

____

Names of current residents you know or personal non-family references.

Name ____________________________ Relationship _____________
Address _______________________________ Phone ____________
Cell Phone ____________

Name ____________________________ Relationship _____________
Address _______________________________ Phone ____________
Cell Phone ____________

Name _____________________________ Relationship _____________
Address __________________________ ______Phone ____________
Cell Phone ____________

Health History

List your medical limitations

____
____
____

Please explain needs for special attention by nursing staff

____
____
____

List of medications (use extra page if necessary)

____
____

List serious illnesses, hospitalizations or operations in the last five years

____
____

Primary Physician

Name:______________________________ Phone: ____________
Address ____

Criteria for Self Care (may include help of a spouse)

- You must be able to self ambulate in your room.
- You must be able to dress and undress.
- You must be able to use the restroom without assistance.
- You must be in a physical or mental state to live alone, with the potential occasional custodial care.
- You must be able to live in a communal setting without conflict with other residents or staff.
- You must be able to perform normal activities of daily living (ADLs)
- You must be able to maneuver to the dining room and to locate your room without assistance.

Fairhaven has the right to transfer a resident to a higher level of care if any of these criteria is not met.

Your **power of attorney** for health care is:
Name ___________________ Relationship _________________
Address ____________________________________ Phone ________

Financial Statement
Value of current assets

Real Estate Holdings $__________________ Loan or Debt $__________

Stocks and bonds $__________________

Checking account (s) $__________________

Savings account (s) $__________________

Other $__________________
(please explain) ____
Total Assets (less loans)__________________

Monthly Income

Social Security $__________________

Pensions / profit sharing__________________

Interest & dividends $__________________

Annuities $__________________

Other $__________________
(please explain) ____
Total Income / month $__________________

Long term care insurance

Company ______________________________ Policy # _______________
Define coverage ____

Payment of monthly fees

To whom should the Fairhaven monthly bill be sent? _________________
Your **power of attorney** for finance is:
Name ___________________________________ Relationship __________
Address _____________________________________Phone ____________
Cell Phone _______________

*All information will be kept confidential and not compromised in any way.

Social Security Number ______________________ (copy of card for file)

Medicare Number ______________________ (copy of card for file)

Race ___________________

In case of Emergency Notify

Name ______________________________ Relationship ____________
Address ____________________________ Phone _________________
Cell Phone _______________

Name ______________________________ Relationship ____________
Address ____________________________ Phone _________________
Cell Phone _______________

Name ______________________________ Relationship ____________
Address ____________________________ Phone _________________
Cell Phone _______________

Personal Health Insurance

(Copy of information for file)

Company __________________ Address ______________________

Group # ______________________ Policy # _____________________

End of Life Arrangements

Mortician ______________________________ Phone _______________

Address ____

Cemetery ______________________________ Phone _______________

Address ____