Print Form

the Villa at Saint Antoine

THE ULTIMATE IN ASSISTED LIVING

PERSONAL APPLICATION AND HEALTH QUESTIONNAIRE

Thank you for your interest in The Villa at Saint Antoine. In order to be considered for residency, please complete this application and questionnaire in full. The information requested will help us to assess your ability to live at The Villa. If you need assistance in completing this form, call us at 401-767-2574, we will be happy to help you.

Please return the completed application to:
Attn.: Tammy Summiel, Administrator
The Villa at Saint Antoine
400 Mendon Road
North Smithfield, Rhode Island 02896
P: 401-767-2574 F: 401-767-2581

PERSONAL HISTORY

Applicant Name _____

Address _____

City_____ State _____ Zip _____

Telephone _____How long at this address?_____

Rent _____ Own _____ Email address _____

Social Security Number _____

Medicare Number _____

Secondary Insurance Number_____

Do you have long term care insurance? _____ Company _____

Date of Birth_____ Place of Birth _____

Marital Status:_____ Former Occupation _____

Will you be bringing a car to The Villa at Saint Antoine? _____

Do you live alone?_____ If no, with whom? _____

Religious Preference _____

Parish, if applicable _____

How did you learn about The Villa at Saint Antoine? _____

_____

Name of Contact Person _____

Relationship _____ Legal Designation, if any _____

Address_____

City _____ State _____ Zip _____

Telephone: Day _____ Evening _____

E-mail address _____

Emergency Contact, if different from Contact Person named above

Name _____

Address _____

City _____ State _____ Zip _____

Telephone: Day _____ Evening _____

E-mail address _____

Do you have any of the following?

Durable Power of Attorney for Health Care _____
Health Care Proxy _____
Living Will _____
General Power of Attorney _____
Guardian _____

If yes to any of the above:

Name _____

Address_____

City _____ State _____ Zip _____

Telephone: Day _____ Evening _____

E-mail address _____

Name of person to whom all correspondence should be addressed

Name _____

Address _____

City _____ State _____ Zip _____

Telephone: _____ Evening _____

E-mail address_____

MEDICAL INFORMATION

Primary Physician's Name _____Telephone _____

Address_____

How would you describe your present state of health? _____

_____

Do you have a health condition that requires regular daily attention or monitoring (i.e., insulin, medications, blood pressure, skin condition)?

Describe _____

Who monitors it now? _____

List the medical specialists you see:

Name_____ Specialty _____ Phone # _____

Name_____ Specialty _____ Phone # _____

Name_____ Specialty _____ Phone # _____

List medications you are taking now.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Describe any assistance you need with medications? _____

_____

Are you experiencing memory problems? _____ Explain _____

_____

Do you prepare your own meals? _____ if no, who is? _____

Are you on a special diet? _____ If yes, please describe _____

_____

_____

How much walking do you do? _____

Do you use an assistive device? Cane _____ Walker_____ Other _____

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

I = Independent **M = Moderate Assist** **T = Total Assist**

	Rating	**Comments**
Bathing	_____	_____
Dressing	_____	_____
Walking	_____	_____
Housekeeping	_____	_____
Laundry	_____	_____
Finances	_____	_____
Shopping	_____	_____
Transportation	_____	_____
Safety Awareness	_____	_____

Other: Explain: _____

Is incontinence a problem? _____ Explain_____

_____

I authorize my physician(s) to release medical information to The Villa at Saint Antoine for purposes of application and residence.

Signed _____ Date_____

FINANCIAL INFORMATION

1st Applicant Name_____

Social Security # _____

2nd Applicant Name (if any)_____

Relationship _____

Social Security _____

	1st APPLICANT	2nd APPLICANT
ASSETS		
Equity in Residence	$_____	$_____
Savings & CD's	$_____	$_____
Investments	$_____	$_____
Trusts	$_____	$_____
Other	$_____	$_____
Total	$_____	$_____
LIABILITIES		
Mortgage	$_____	$_____
Loans	$_____	$_____
Other	$_____	$_____
Total	$_____	$_____
MONTHLY INCOME		
Social Security	$_____	$_____
Pension/Annuities	$_____	$_____
Interest/Dividends	$_____	$_____
Trust	$_____	$_____
Other	$_____	$_____
Total	$_____	$_____

Does the death of one applicant alter the income or assets of the other applicant? _____

Explain _____

_____

Does someone other than you administer your finances? Yes_____ No_____ If yes,

Name _____

Relationship _____

Address _____

Telephone: Day _____ Evening _____

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

_____ _____
Signature of 1st Applicant Date

_____ _____
Signature of 2nd Applicant Date

_____ _____
Responsible Party, if applicable Date

PHYSICIAN'S MEDICAL QUESTIONNAIRE

*******TIME SENSITIVE DOCUMENT*******

Patient Name: _____

Date of Birth: _____

Physician's Name: _____

Physician's Address: _____

_____

Physician's Telephone: _____

Physician's Fax: _____

I hereby authorize the above named physician to release medical information requested by the Villa at Saint Antoine. This information will be kept confidential and it will be used only for the purpose of determining the most appropriate level of service to meet the above named patient.

_____ _____

Patient's Signature Date

the Villa at Saint Antoine

THE ULTIMATE IN ASSISTED LIVING

PLEASE COMPLETE QUESTIONAIRE AND RETURN TO:

Attention: Director of Wellness

400 MENDON ROAD NORTH SMITHFIELD, RI 02896

PHONE: 401-767-2574 FAX: 401-767-2581