

A GOOD LIFE ASSISTED LIVING
731 Hollen Rd. Baltimore MD 21212 (443) 493-7575

APPLICATION FOR RESIDENCE

Name of Client: _____ Phone: _____
Address: _____ Zip Code: _____
DOB: _____ Age: _____ Sex: _____ Ht: _____ Wt: _____
Physician(s) name and Phone#s: _____

Representative: _____ Relationship: _____
Address: _____ Email: _____
Home Phone: _____ Cell Phone: _____

Additional Contacts: _____

What service is this individual being referred for? _____ **Respite Care** **Assisted Living**

INSURANCE/PAYMENT INFORMATION: MEDICAID#: _____ MEDICARE#: _____

OTHER INSURANCE: _____ LONG TERM CARE: _____

MONTHLY INCOME: Social Security: _____ Retirement: _____ Other: _____

Do you have a: () Power of Attorney; () Durable Power of Attorney; () Guardian; () Living Will

HEALTH INFORMATION: (check all of those that apply):

____ Dementia ____ High BP ____ Depression ____ Stroke ____ Fall ____ Pain ____
____ Arthritis ____ Heart Problems ____ Diabetes ____ SOB ____ Congestive Heart Failure

Allergies: (Food and/or Medication): _____ DNR: ____ Yes ____ No

Has the client been diagnosed with Alzheimer? Yes ____ No ____

ADDITIONAL HEALTH PROBLEMS/DIAGNOSIS:

Individual has difficulty with: ____ Hearing ____ Speech ____ Vision ____ Swallowing
____ Sleeping ____ Walking

Individual Exhibits:
____ Confusion ____ Wandering ____ Hostility/Anger ____ Anxiety ____ Combativeness
____ Poor Balance ____ Risk of Falling ____ Hallucinations ____ Delusions

Other Special Needs/Safety Concerns: _____

Dietary Restrictions: _____

FUNCTIONING: (check those that apply)

Ambulation:	____ Independent	____ Stand with Assistance	____ Physical Assistance
Assistive Device:	____ Cane	____ Walker	____ Wheelchair
Transferring:	____ Independent	____ Stand with Assistance	____ Total Assistance
Toileting:	____ Independent	____ Reminding	____ Physical Assistance
Bathing:	____ Independent	____ Supervision	____ Assistance
Dressing:	____ Independent	____ Supervision	____ Assistance
Feeding:	____ Independent	____ Reminding	____ Physical Assistance

For Respite Services only:

Number of days a week requested > 7 days: ()

How did you hear about Mandeville House? _____ Physician ____ Friend ____ Web Site
____ Family ____ Newspaper ____ Other: _____

Signature of Person Completing Form Date