Application for Residency in Hospice Center

Date: ______________

<u>Personal Information</u>:

Full Name: ____

Date of Birth: ____________________ Male/Female________________

Current Address: ____

____

Current Telephone #:____

Marital Status: Married_____ Widowed_____ Divorced _____ Single_____

Medical Diagnosis: ____

<u>Primary Caregiver (Family member or friend to be Resident's Designated Agent)</u>

Full Name: ____

Address: ____

Home Telephone #: _________________ Alternate #: _________________

Relationship to Applicant: ____

<u>Power of Attorney (if he/she is different from the Primary Caregiver)</u>

Full Name: ____

Address: ____

Home Telephone #:___________________ Alternate #: _________________

Relationship to Applicant: ____

Advance Directive or Living Will? Yes ______ No _____

Health Care Agent Named (Durable Power of Attorney)? Yes ____ No ____

If yes, please complete the following:

Full Name: ____

Address: ____

Home Telephone #:___________________ Alternate #: _________________

Relationship to Applicant: ____

Funeral Arrangements have been made: Yes______ No _____

If yes, please complete the following:

Funeral Home: ____

Location: ____

In a few words, please share with us the primary reason residency is sought:
(This may be written or typed and attached on a separate paper, if preferred.)