Grandview Terrace
114515 W. Granite Valley Drive
Sun City West, AZ 85375
623/975-8014
623/546-3752 Fax

APPLICATION FOR RESIDENCY

Note: Please complete a separate application for each individual to reside in Grandview Terrace. Please answer all questions as completely and accurately as possible. This information will be held in strict confidence. Please bring this completed form to your application appointment or mail to the address listed above. Additionally, a Physician's Statement form must be completed by your doctor prior to residency. Attach additional pages, if necessary.

PERSONAL HISTORY

Last Name: ______________________________ First Name: ____________________ M.I.: _____

Address: ____ Phone #: (____) ____________

City: ___________________________________ State: ________________ Zip: ____________

How long have you been at your current address: ____

Date of Birth: _______/_______/_______ Place of Birth: _________________________________

Social Security Number: ________/________/________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Remarried

Spouse's Name: _______________________ Spouse's Social Security Number: _______/_______/__________

Where have you lived most of your life? ____

Previous Occupation(s): ____

List Hobbies: ____

List Community Service Activities: ____

Are you acquainted with any of our existing residents? ☐ Yes ☐ No

If so, please list names: ____

____

Are you a veteran? ☐ Yes ☐ No Please list date of service: ______________________________

What church / other religious organizations, if any, are you a member: _______________________

Contact name: ____ Phone #: (____) _______________

FAMILY HISTORY

List your close relatives starting with children first, if any:

Name: ______________________________________ Relationship: ________________________

Address: ____

Occupation: _____________________ Home Phone: (____) __________ Business Phone: (____) ________

Name: ______________________________________ Relationship: ________________________

Address: ____

Occupation: _____________________ Home Phone: (____) __________ Business Phone: (____) ________

Name: ______________________________ Relationship: ______________________

Address: ____

Occupation: __________________ Home Phone: (____) __________ Business Phone: (____) ________

Name: ______________________________ Relationship: ______________________

Address: ____

Occupation: __________________ Home Phone: (____) __________ Business Phone: (____) ________

Name: ______________________________ Relationship: ______________________

Address: ____

Occupation: __________________ Home Phone: (____) __________ Business Phone: (____) ________

Name: ______________________________ Relationship: ______________________

Address: ____

Occupation: __________________ Home Phone: (____) __________ Business Phone: (____) ________

HEALTH HISTORY

Can you care for your normal needs: ☐ Yes ☐ No If no, list limitations: ______________________

Do you have a Guardian: ☐ Yes ☐ No If yes, provide Guardianship documents.

Do you have a medical Power of Attorney? ☐ Yes ☐ No

Do you have a financial Power of Attorney? ☐Yes ☐ No

Do you have a Living Will? ☐ Yes ☐ No

Have you ever been diagnosed as having or been treated for any of the following:

	Yes	No	Comments
Heart Trouble	____	____	______________________
Epilepsy	____	____	______________________
Cancer	____	____	______________________
Tuberculosis	____	____	______________________
Diabetes	____	____	______________________
Alzheimer's Disease	____	____	______________________
High Blood Pressure	____	____	______________________
Parkinson's Disease	____	____	______________________

Primary Physician's Name: ______________________________ Phone #: (____) __________

Address: ____

Other Physicians you see:

Name: ____________________ Specialty: ________________ Phone #: (____) __________

Name: ____________________ Specialty: ________________ Phone #: (____) __________

Name: ____________________ Specialty: ________________ Phone #: (____) __________

Supplemental Insurance:

Do you have employment related health insurance: ☐ Yes ☐ No If yes, list company name: ______________

Insurance company: ______________________________ Phone #: (____) __________

Group #: __________________________ ID #: ______________________________

Other Supplemental / Nursing Home or Long-term Care Insurance:

Insurance company: ______________________________ Phone #: (____) __________

Group # / Policy #: ____________________ ID #: ______________Type: ______________

Insurance company: ______________________________ Phone #: (____)__________

Group # / Policy #: ____________________ ID #: ______________Type: ______________

FINAL PLANS

We request that final plans / burial arrangements be made in advance to residency. Please list the following contact information:

Emergency contact: ______________________________ Relationship: _______________ Phone #: (____) _____________

Emergency contact: ______________________________ Relationship: _______________ Phone #: (____) _____________

Funeral Home: __________________________________ ID Info: ____________________ Phone #: (____) _____________

Attorney: ______________________________________ Firm: ______________________ Phone #: (____) ______________

CONFIDENTIAL FINANCIAL STATEMENT

List companies and amounts of life insurance:

Company / Policy Number	Amount	Beneficiary

Are you the beneficiary of a life insurance policy:

Company / Policy Number	Amount	On Whose Life

Do you owe any debts: ☐ Yes ☐ No

Creditor	Amount	Terms / Details

Are any debts owed to you: ☐ Yes ☐ No

Creditor	Amount	Terms / Details / How Secured

In the event of death of a spouse, does any portion of your monthly income terminate:

☐ Yes ☐ No If yes, by what amount: $_____________________

ASSETS

List all assets (excluding personal property i.e., furnishings and vehicles) giving descriptions and approximate value. This should include cash, deposits, stocks, bonds, real estate, prepaid insurance, etc.

Description	Value
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
	$
Total	$

INCOME

List **ALL** income, giving description and approximate annual amount. Be sure to include income from all sources including investments where interest may be reinvested.

Source / Type

______________________________ $______________

______________________________ $______________

______________________________ $______________

______________________________ $______________

______________________________ $______________

______________________________ $______________

______________________________ $______________

TOTAL ANNUAL INCOME $______________

Are you financially responsible for the care of another individual: ☐ Yes ☐ No

If yes, give details, relationship, annual financial amount: ______________________________

Your bank(s) Name:	Contact name (if any)	Address

Location of safe deposit box: ______________________________

MISCELLANEOUS INFORMATION

Why do you wish to move to Grandview Terrace? ______________________________

With whom are you living now: ______________________________

____

I make this application to Grandview Terrace of my own free will and accord. It is my purpose to make Grandview Terrace my permanent home and the State of Arizona my legal residence. I declare the answers to the foregoing to be true, full and complete.

Date: ______________ Your Signature: ______________________________

Date: ______________ Approved By: ______________________________ for Grandview Terrace

We are pledged to the letter and spirit of U.S. policy for the achievement of equal housing opportunity throughout the Nation. We encourage and support an affirmative advertising and marketing program in which there are no barriers to obtaining housing because of race, color, religion, sex, handicap, familial status or national origin.

For Office Use

____

____

____

____

____