

La Loma Village
14154 Denny Blvd
Litchfield Park, AZ 85340
(623) 537-7500
(623)975-8805 Fax

APPLICATION FOR ADMISSION

Note: Please complete a separate application for each individual to reside in La Loma Village. 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:

	<u>Yes</u>	<u>No</u>	<u>Comments</u>
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: _____

