Resident Application

Fairhaven

Christian Retirement Center

3470 N Alpine Rd
Rockford, IL 61114
815-877-1441
www.fairhaven.cc

I declare that
the information on this application is complete and accurate. I also agree with the **Criteria for self care** found on page 4 (health information section) which will become part of my permanent record.

Resident Name (printed) _____

Resident Signature/POA _____

Date _____

This information will be reviewed by the admittance committee and you will be advised of its acceptance. If you go on our waiting list, health and financial information may need to be updated when we have suitable accommodations and you are ready to move in.

Last Name _____Legal First Name _____ MI ____

Address _____City _____

State _____ Zip _____ Phone _____ Cell _____

Resident Email address _____

Date of Birth _____ Age _____ Male ____ Female ____

Family & Personal History

Place of Birth _____

Parent's names _____ Mother's Maiden Name _____

Marital Status

Single _____ Married _____ Widowed _____ Divorced _____

Spouse's name _____ Anniversary Date _____

Number of Siblings _____ Children _____ Grand Children _____
Great Grandchildren _____

Closest relatives or friends concerned with your well being
Name _____ Relationship _____
Phone _____ Address_____
Cell Phone _____

Name _____ Relationship _____
Phone _____ Address_____
Cell Phone _____

Name _____ Relationship _____
Phone _____ Address_____
Cell Phone _____

Education and training _____

Previous occupation_____ Employer _____

Military service _____ Branch _____

Church & spiritual relationships

Church _____ Pastor _____

Denomination _____

Address _____ Phone _____

Years of membership _____

Services performed for your church

_____

Fairhaven Christian Retirement Center is an affiliate of the Great Lakes District of the Evangelical Free Church of America. Would you be able to be comfortable in this Christian environment? _____
Comments _____

Social Interests

Where have you traveled

_____

Names of clubs and organizations you are or have been affiliated with

_____

Hobbies and interests

_____

Names of current residents you know or personal non-family references.

Name _____ Relationship _____
Address _____City_____ State ____Zip _____
Phone _____ Cell Phone _____

Name _____ Relationship _____
Address _____City _____State _____Zip _____
Phone _____ Cell Phone _____

Name _____ Relationship _____
Address _____City _____State ____ Zip _____
Phone _____ Cell Phone _____
What are your reasons for wanting to become a resident at Fairhaven.

_____

_____

Health History

List your medical limitations

_____
_____
_____

Please explain needs for special attention by nursing staff

_____
_____
_____

List of medications (use extra page if necessary)

_____
_____

List serious illnesses, hospitalizations or operations in the last five years

_____
_____

Primary Physician

Name:_____ Phone: _____
Address _____

Criteria for Independent Living Self Care (may include help of a spouse)

- You must be able to self ambulate in your room.
- You must be able to dress and undress.
- You must be able to use the restroom without assistance.
- You must be in a physical or mental state to live alone, with the potential occasional custodial care.
- You must be able to live in a communal setting without conflict with other residents or staff.
- You must be able to perform normal activities of daily living (ADLs)
- You must be able to maneuver to the dining room and to locate your room without assistance.

Fairhaven has the right to transfer a resident to a higher level of care if any of these criteria is not met.

Your **power of attorney** for health care is:
Name _____ Relationship _____
Address _____
City_____State _____Zip_____
Phone _____ Cell _____
Email address: _____

Financial Statement
Value of current assets

Real Estate Holdings $_____ Loan or Debt $_____

Stocks and bonds $_____

Checking account (s) $_____

Savings account (s) $_____

Other $_____
(please explain) _____
Total Assets (less loans)_____

Monthly Income

Social Security $_____

Pensions / profit sharing_____

Interest & dividends $_____

Annuities $_____

Other $_____
(please explain) _____
Total Income / month $_____

Long term care insurance

Company _____ Policy # _____
Define coverage _____

Payment of monthly fees

To whom should the Fairhaven monthly bill be sent? _____
Your **power of attorney** for finance is:
Name _____ Relationship _____
Address _____
City _____State _____ Zip _____
Phone _____Cell Phone _____
Email address: _____

***All information will be kept confidential and not compromised in any way.**

Social Security Number _____ (copy of card for file)

Medicare Number _____ (copy of card for file)

Race _____

In case of Emergency Notify

Name _____Relationship _____
Address _____ Phone _____
Cell Phone _____

Name _____Relationship _____
Address _____ Phone _____
Cell Phone _____

Name _____Relationship _____
Address _____ Phone _____
Cell Phone _____

Personal Health Insurance
(Copy of information for file)

Company _____ Address _____

Group # _____ Policy # _____

End of Life Arrangements

Mortician _____Phone _____

Address _____

Cemetery_____ Phone _____

Address_____