Seabury at Springvale Terrace
Senior & Assisted Living

FOR OFFICE USE ONLY

*Date Rec'd*_____

Time Rec'd _____

Rec'd By _____

SPRINGVALE TERRACE
ASSISTED LIVING APPLICATION FOR ADMISSION
8505 SPRINGVALE ROAD
SILVER SPRING, MARYLAND 20910
Phone # (301) 587-0190
FAX # (301) 588-1126

Name of Applicant_____ **Social Security Number** _____

Applicant's Present Address_____**Zip**_____

Age_____**Birthdate****Birthplace**_____**Marital Status**_____**Phone Number** _____

Present Living Arrangements _____

Home Address or
Last Address if Different _____

CORRESPONDENCE INFORMATION

Person Supplying Information_____**Relationship** _____

Person To Whom Correspondence Should Be Sent _____
Address_____**Phone Number** _____

E-mail Address: _____

HEALTH INSURANCE INFORMATION (Please provide copies of all health insurance cards)

Medicare Number_____**Part A (Effective Date)**_____**Part B (Effective Date)** _____

Medicaid Number_____**Eligibility Date** _____

Other Health Insurance_____**Policy Number:** _____

Address_____**Phone Number** _____

Long-Term Care Insurance_____**Effective Date** _____

Address_____**Phone Number** _____

Prescription Medication Insurance Plan _____ **Effective Date** _____

EDUCATIONAL/EMPLOYMENT HISTORY

Educational Level_____ **Religion** _____

Previous Occupation(s) _____

Retirement Date(s)_____

Service in the Armed Services? Yes _____ **No** _____ **Spouse? Yes** _____ **No** __

Branch of Service _____

This facility does not discriminate on the basis of race, color, religion, national origin, sex, elderliness, familial status, or handicap in the admission or access to, and/or treatment and employment in, its federally assisted programs and activities. Occupancy is open to all persons that meet the facility's eligibility criteria, regardless of the aforementioned federal and state statutorily protected classes.

	NAME	ADDRESS	PHONE
ATTENDING PHYSICIAN:			
DENTIST:			
HOUSE OF WORSHIP/ CLERGY:			
LOCAL SOCIAL SERVICE DEPT/CASEWORKER:			
PREFERRED FUNERAL HOME:			
OTHER INTERESTED AGENCY:			

PHYSICAL CONDITION OF APPLICANT

Has Applicant ever been in a hospital? Yes _____ No _____

Latest Admission Date_____Latest Discharge Date_____Name of Hospital_____

Reason for Most Recent Admission _____

Has Applicant ever been in a nursing home or rehab center? Yes _____ No _____ Latest Admission Date _____

Latest Discharge Date_____Name of Home _____

_____ Reason for Admission _____

_____

Has the applicant ever been in another assisted living or retirement community? Yes _____ No _____

Name of assisted living community (ies): _____

Reason for leaving_____

Please check all limitations that are applicable:

☐ **Eyesight** ☐ **Hearing** ☐ **Uses Crutch,Cane,Walker** ☐ **Wheelchair** ☐ **Heart Trouble**

☐ **Epilepsy** ☐ **Cancer** ☐ **Tuberculosis** ☐ **Diabetes** ☐ **High Blood Pressure**

Any Contagious Disease_____Paralyzed_____Physical Deformity _____

Does the Applicant handle his/her own finances?	☐ **Yes**	☐ **No**
Can the Applicant use the bathroom without assistance?	☐ **Yes**	☐ **No**
Can the Applicant bathe without assistance?	☐ **Yes**	☐ **No**
Can the Applicant dress himself/herself?	☐ **Yes**	☐ **No**
Can the Applicant do light housekeeping chores such as dusting?	☐ **Yes**	☐ **No**
Can the Applicant prepare meals safely for himself/herself?	☐ **Yes**	☐ **No**

List all prescription and non-prescription medications taken by the Applicant. _____

_____

PERSONAL / SOCIAL DATA

Description of Family Structure and Relationships:
Hobbies and Interests:
Previous Mental Health Issues:
Current Behavioral and Social Functioning Including Strengths and Problems:
Substance Abuse History:

EMERGENCY INFORMATION

In case of serious illness, emergency or death, whom should the facility staff notify?

Name_____ **Telephone** _____

Address _____

Names and Addresses of Living Children or Nearest Relatives:

Name_____ **Name** _____

Address_____ **Address** _____

Telephone_____ **Telephone**_____

Relationship_____ **Relationship**_____

E-mail address: _____ **E-mail address:** _____

Name_____ **Name** _____

Address_____ **Address** _____

Telephone_____ **Telephone**_____

Relationship_____ **Relationship** _____

E-mail address: _____ **E-mail address:** _____

LINENS AND FURNISHINGS

PERSONAL LAUNDRY RESPONSIBILITY ☐ **Family** ☐ **Facility** ☐ **Other** _____

WILL THE APPLICANT BE ABLE TO PROVIDE:	**Yes**	**No**
Bed linens: Minimum of 2 complete sets of sheets, 2 blankets, bedspread		
Bath linens: Minimum of 3 complete sets (wash cloth, hand cloth, bath towel)		
Unit Furnishings? If so, please list:		

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ACCOMMODATION INFORMATION

Unit Requested: ☐ **Studio** ☐ **One Bedroom** ☐ **SharedSuite** ☐

Anticipated Move-In Date: _____

Automobile: Model/Year_____**License Number:** _____

COMPLETE CONFIDENTIAL FINANCIAL DISCLOSURE STATEMENT

I/We have read the requirements and desire to be considered for residence. I/we certify that all information given on this application is correct to the best of my/our knowledge and give consent to the management to verify it. I/We understand that this application is confidential and only for the purpose of processing my/our application.

Signature_____ **Date** _____

Signature_____ **Date** _____

OFFICE USE ONLY

Date Received:_____Date of Acceptance: _____

Interview Date:_____Decision: ☐ Admission ☐ Rejection

OFFICE USE ONLY

DISCHARGE INFORMATION

Date of Discharge_____**Reason for Discharge** _____

Discharge Location: _____

Name: _____

Address: _____

_____

Phone: _____

Name of Person and Phone Number to Notify of an Emergency Discharge: _____

_____

Date of Emergency Discharge: _____

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