Tohono O'odham Elder Assisted Living Residence

APPLICATION
Resident or Prospective Resident

Todays Date:		Schedule Occupancy Date:	
Resident's Full Name:			Preferred to be called:
Current Address:			
Martial Status:	If married, Spouse Name:	Age:	DOB:
SSN:	Tribal ID #:	District:	Community:
Whom do you currently live with? Relation:			
Health Insurance/Policy#		Secondary Health Insurance/Policy #	
Primary Care Provider Name/location			Date of last visit:

Do you receive the following services from Tohono O'odham Health Care: (check)

□ Podiatry □ Dental □ Vision □ Physical Therapy □ Other

Advance Directives: (check)	□ Living Will	□ DNR or No-code	□ Prehospital Medical Care Directive	□ Do-not-transport order	Medical Power of Attorney/Name:

Resident's Representative or Responsible Party:				Relationship
Home Phone:	Work Phone:	Cell Phone:		Email:
Address:		City:		Zip:
Emergency Contact:				Relationship
Home Phone:	Work Phone:	Cell Phone:		Email:
Address:		City:		Zip:

Continue Application

Resident Name:

Description of Care Needs

Physical aids worn, used or brought into the home:

□ Pacemaker	□ Dentures	□ Partial Plate - top or bottom (circle)	□ Prosthetic Device	□ Wheelchair	□ Walker
□ Glasses	□ Contact Lenses	□ Hearing Aid	□ Other/explain		

Needs help with:

□ Walking	□ Dressing	□ Bathing	□ Eating	□ Dental Hygiene	□ Toileting	□ Catheter	□ Incontinence Care
□ Medications		□ Transfer		□ Wondering	□ Other/explain		

Resident suffers from:

□ High Blood pressure	□ Osteoporosis	□ Heart Prolems	□ Deafness	□ Paralysis	□ Cataracts
□ Glaucoma	□ Arthritis	□ Confusion	□ Chronic Diarrhea	□ Constipation	□ Cancer
□ Lung Disease	□ Liver problems	□ Thyroid Dificiency	□ Parkinson's	□ Depression	□ Diabetes
□ Memory loss	□ Alzheimer's	□ Alcoholism	□ Other/explain		

Resident Personal History

Religious Preference:	Name of Church:
Education:	
Occupation(s):	
Children's Names:	
Favorite Food:	Allergies:

Signature: _____

Signer is: □ Resident □ Gaurdian □ Conservator □ Power of Attorney

Other: _____

For Use At Time Of Discharge

Discharge Information

Date of Discharge: _____ Circumstances: _____

Relocation assistance provided by the Assisted Living: _____

Forwarding Address: