Apartment Application

Heritage House at the Market

1533 Western Avenue, Seattle, Washington 98101

Telephone (206) 382-4119 Fax (206) 382-0201

Today's Date:	**How Soon Do You Want To Move In?** ☐ As soon as possible ☐ Not sure, would like to talk about it ☐ In the future- when?		
Name- First:	**Middle:**	**Last:**	**What you prefer to be called:**

Current Address:	**Apt #:**	**City:**	**State:**	**Zip:**

Current Phone #:	**Social Security #:**	**Marital Status:** **S M W D**

Date of Birth:	**Age:**	**Birth Place- City/State:**	**Former Occupation:**	**Religious Preference:**

Race (optional):	**Hospital Preference:**	**Pharmacy Preference:**	**Funeral Home Preference:**

Medicare #:	**Medicare Part D Prescription Plan:**	**Policy #:**

Medicaid #:	**PIC #:**	**Other Medical Insurance:**	**Policy #:**

Durable Power of Attorney for Health Care: ☐ No ☐ Yes Name:	**Durable Power of Attorney for Finance:** ☐ No ☐ Yes Name:	**Legal Guardian:** ☐ No ☐Yes Name:

Advanced Directives:

☐ POLST ☐ CPR Decision ☐ Directive to Physicians ☐ Does NOT have Advanced Directives

Primary Physician:	Phone #:	Fax #:	
Address:	City:	State:	Zip:
Dentist:	Phone #:	Fax #:	
Address:	City:	State:	Zip:
Eye Doctor:	Phone #:	Fax #:	
Address:	City:	State:	Zip:
Podiatrist:	Phone #:	Fax #:	
Address:	City:	State:	Zip:
Other Health Care Provider:	Phone #:	Fax #:	
Specialty:	Address:	State:	Zip:

Family/ Friend Contacts:

Primary Contact Name:		Relationship:	
Address:		State:	Zip:
Home Phone #:	Cell Phone #:	Work Phone #:	
Name:		Relationship:	
Address:		State:	Zip:
Home Phone #:	Cell Phone #:	Work Phone #:	
Name:		Relationship:	
Address:		State:	Zip:
Home Phone #:	Cell Phone #:	Work Phone #:	
Name:		Relationship:	
Address:		State:	Zip:
Home Phone #:	Cell Phone #:	Work Phone #:	

Financial Information

Monthly Income:	Assets to Draw Upon:	Other Resources:	Other:

Who will be responsible for handling your financial affairs?

Name:		Relationship:	
Address:		State:	Zip:
Home Phone #:	Cell Phone #:	Work Phone #:	

A non-refundable security deposit of $500.00 is required upon agreement to move in.
Medicaid applications are exempt from this deposit.

ABOUT YOUR HEALTH

These are my current Health problems:

Do you have any wounds, rashes or areas of broken skin? ☐ No ☐ Yes- please list:

Are you diabetic? ☐ No ☐ Yes- If yes, how do you manage it? (check all that apply)
☐ Diet ☐ Medication
☐ Insulin Shots- How many times a day? _______
☐ Blood Sugar Checks- How many times a day? _______
Comments:

Do you have problems with pain? ☐ No ☐ Yes
If yes:
How often do you have pain? ☐ Occasionally ☐ Frequently ☐ Daily ☐ At Night
How bad is your pain? ☐ Mild ☐ Moderate ☐ Severe ☐ Varies
Where is your pain?
What helps your pain?

Do you smoke? ☐ No ☐Yes, please give details:

Do you have any problems with your memory? ☐ No ☐ Yes, please give details:

Your vision: ☐ Normal ☐ Impaired- what's wrong?
Vision correction? ☐ None ☐ Glasses/Contact lenses- details:

Your hearing: ☐ Normal ☐ Impaired- what's wrong?
Hearing aides? ☐ No ☐ Yes—☐ Right Ear ☐ Left Ear ☐ Both Ears

Do you wear dentures? ☐ No ☐ Yes- check all that apply ☐ Upper ☐ Lower ☐ Partial
Comments/Other oral needs:

Do you use any mobility aides? ☐ No ☐ Yes- check all that apply ☐ Cane ☐ Walker ☐ Wheelchair
Other:

Your bladder: ☐ No problems ☐ Occasional problems- what?
If you have problems, how do you manage?

Your bowels: ☐ No problems ☐ Occasional problems- what?
If you have problems, how do you manage?

Have you fallen in the last 12 months? ☐ No ☐ Yes, please give details:

Do you take any prescription medications? ☐ No ☐ Yes, please list:

Do you take any over the counter medications? ☐ No ☐ Yes, please list:

Do you have any allergies to medications? ☐ No ☐ Yes, please list:
Do you have any food allergies? ☐ No ☐Yes, please list:
Do you have any other allergies? ☐ No ☐ Yes, please list:
Which pharmacy provides your medications and how do you get the medications to your home?
What kind of help do you need with your medications? ☐ No help needed ☐ Just opening the containers for me- I remember to take my meds otherwise ☐ Someone to bring me my meds daily and remind me to take them ☐ A nurse to give me my meds- reason:
Do you have problems with your blood pressure? ☐ No ☐ Yes- what?
Do you have problems with your weight? ☐ No ☐ Yes- ☐ Weight loss ☐ Weight gain Comments:
Is there any other health information you think we should know? ☐ No ☐ Yes, please give details:
How can we help you with your health? ☐ I don't want any help ☐ I'm not sure, but I want to talk about it ☐ Here is what I want:

ABOUT YOU
Sleep Habits:
I like to get up: ☐ Early- when? ☐ Late- when? ☐ In- between- when? Comments:
I like to go to bed: ☐ Early- when? ☐ Late- when? ☐ In- between- when? Comments:
I like to take naps: ☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ Daily Comments:
I have trouble sleeping: ☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ Every Night Comments: **What helps you sleep better?**

Food:

I like to eat breakfast: ☐ Daily ☐ Occasionally ☐ Never
My favorite breakfast foods:

I like to eat lunch: ☐ Daily ☐ Occasionally ☐ Never
My favorite lunch foods:

I like to eat dinner: ☐ Daily ☐ Occasionally ☐ Never
My favorite dinner foods:

I like to snack: ☐ Never ☐ Rarely ☐ Occasionally ☐ Often ☐ Every Day
My favorite snack foods:

My favorite hot beverages:
My favorite cold beverages:

I need a special diet: ☐ No ☐ Yes, please give details:

Hobbies, Interests and Lifestyle:

Are there close friends or family members you enjoy spending time with? ☐ No, none in particular
☐ Yes- who?

Do you have any special hobbies or interests? ☐ No, none in particular ☐ Yes- what?

Do you have any spiritual preferences you would like us to know about? ☐ No, none in particular
☐ Yes- what?

What is your primary language? ☐ English ☐ Other- what?

Do you have any problems with speaking or making yourself understood when speaking to others?
☐ No ☐ Yes, please give details:

Do you have any problems understanding others? ☐ No ☐ Yes, please give details:

Are there any life events you would like us to know about? ☐ No, none in particular ☐ Yes- what?

Is there anything else you want us to know about your life, past or present? ☐ No, none in particular
☐ Yes- what?

YOUR NEEDS AND WISHES

Morning Routine: ☐ No, I don't need any help in the morning
☐ Yes, I need some help in the morning- check all that apply
☐ Wake up call or visit ☐ Safety check to make sure I'm okay
☐ Assistance with clothing- what?
☐ Putting on TED hose, socks, shoes, braces- what?
☐ Help with morning grooming tasks- what?
☐ Making my bed ☐ Emptying my trash ☐ Opening my curtains/blinds
Comments/Other Needs:

Evening Routine: ☐ No, I don't need any help in the evening
☐ Yes, I need some help in the evening- check all that apply
☐ Reminder call or visit ☐ Safety check to make sure I'm okay
☐ Assistance with clothing- what?
☐ Taking off TED hose, socks, shoes, braces- what?
☐ Help with evening grooming tasks- what?
☐ Opening up my bed ☐ Emptying my trash ☐ Closing my curtains/blinds
Comments/Other Needs:

Meals: ☐ No, I don't need any help with meals
☐ Yes, I need some help with meals- check all that apply
☐ Reminder call ☐ Escort to meals ☐ Help getting food ready (opening cartons, cutting meat, etc.)
☐ Just walk me to meals for a few days, until I learn my way
Comments/Other Needs:

Throughout the Day: ☐ No, I don't need any help throughout the day
☐ Yes, I need some help throughout the day- check all that apply
☐ Reminders to use the bathroom
☐ Reminders about or ☐ Escort to activities
Comments/Other Needs:

Bathing: I prefer a ☐ bath ☐ shower in the ☐ morning ☐ afternoon ☐ evening
☐ No, I don't need any help with bathing
☐ Yes, I need help with bathing- details:
I need special equipment to help me in the bathroom: ☐ No ☐ Yes, what?

Comments/Other Needs:

Laundry: ☐ I want to do my own laundry ☐ I want staff to do my laundry for me
☐ I have other arrangements for my laundry- details:

Comments/Other Needs:

Medical Appointments: ☐ I want to make my own medical appointments
☐ A family member or ☐ a friend will make my medical appointments- who?
☐ I need staff to assist me in making my medical appointments
☐ I have other arrangements for my medical appointments- details:

Comments/Other Needs:

Transportation: (check all that apply)
☐ I drive myself ☐ I take Metro buses ☐ I use Access ☐ I use DSHS/Hopelink ☐ I take taxis
☐ A family member or ☐ a friend will provide transportation- who?
☐ I have other arrangements for my transportation- details:

Comments/Other Needs:

Is there any other information about you that you want us to know? ☐ No ☐ Yes- what?

Is there anything else you want us to help you with? ☐ No ☐ Yes- what?

Who filled out this form? (check all that apply)
☐ Me (the applicant), no assistance from anyone else
☐ Someone else helped me with ☐ reading ☐ writing- who?
☐ Someone helped me with the answers- who?
☐ Someone else filled it out completely- who and why?

Signed:____

Please Provide Documentation of all Insurance Coverage, Any Advanced Directives and Power of Attorney Forms Upon Acceptance as a Resident of Heritage House at the Market