



10485 Jones Bridge Road • Johns Creek, Georgia 30022
770.475.8787 • www.cohenhome.org

Resident Application

Name of Applicant _____

Date of Birth _____ Place of Birth _____

Present Address _____

Years In Community _____ Home Phone _____

Present Type of Housing Arrangement _____

With Whom Do You Live, If Anyone? _____

Years In Previous Community (Name Community) _____

Marital Status _____

Significant Current Health Conditions _____

Physician _____

Address _____

Phone _____

Dentist _____

Address _____

Phone _____

Highest Level of Education Completed _____

Profession, Occupation, or Trade _____

Are You Currently Employed? Indicate P/T or F/T _____

Employer's Name & Company _____

Address _____

Phone _____

Interests & Hobbies _____

Religious Activities _____

Membership Organizations _____

Emergency Contacts:

<u>Name & Relationship</u>	<u>Address</u>	<u>Email</u>	<u>Home Phone</u>	<u>Alt Phone (work/mobile)</u>
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Applicant's Name _____ Date _____

QUESTIONNAIRE FOR REFERRING RELATIVES – SELF CARE

Circle the letters that best apply in each category:

1. TOILETING

- A. Cares for self at toilet independently, no incontinence.
- B. Needs to be reminded or needs help in cleaning self.
- C. Has occasional accidents.
- D. Is regularly incontinent of bladder.
- E. Is regularly incontinent of bowel.

2. EATING

- A. Eats without assistance.
- B. Eats with minor assistance at mealtimes.
- C. Needs help with cooking or cleaning up after meals.

3. DRESSING

- A. Selects clothes from wardrobe, dresses, and undresses self independently.
- B. Dresses and undresses self with minor assistance.
- C. Needs moderate and regular assistance or supervision in dressing.

4. GROOMING

- A. Always neatly dressed and well groomed without assistance.
- B. Grooms self adequately with occasional minor assistance.
- C. Needs moderate and regular assistance or supervision with grooming.

5. BATHING

- A. Bathes self without assistance.
- B. Bathes self with help getting in or out of the tub or shower.
- C. Washes face and hands only, but cannot bathe the rest of self.
- D. Needs encouragement to bathe.

6. AMBULATION

- A. Walks around grounds or city without assistance.
- B. Ambulates within residence and could walk about a block.
- C. Ambulates with assistance of:
 - ____ Railing
 - ____ Cane
 - ____ Walker
 - ____ Wheel Chair
 - ____ Another Person

Applicant's Name _____ Date _____

QUESTIONNAIRE FOR REFERRING RELATIVES – SOCIAL FUNCTIONING**Circle the letters that best apply in each category:****1. ABILITY TO USE TELEPHONE**

- A. Uses phone on own initiative, looks up numbers and dials independently.
- B. Dials a few well known numbers.
- C. Answers telephone but does not dial.
- D. Does not use telephone without assistance.

2. SHOPPING

- A. Takes care of all own shopping needs.
- B. Shops independently for small purchases.
- C. Needs to be accompanied on all shopping trips.
- D. Completely unable to shop.

3. FOOD PREPARATION

- A. Plans, prepares, and serves adequate meals independently.
- B. Prepares adequate meals if ingredients are supplied.
- C. Heats and serves prepared meals in oven or microwave.
- D. Prepares meals but does not maintain an adequate diet.
- E. Needs to have meals prepared and served.

4. HOUSEKEEPING

- A. Maintains house alone or with occasional assistance.
- B. Performs light daily tasks such as dishwashing and making bed.
- C. Performs light daily tasks but cannot maintain acceptable level of cleanliness or organization.
- D. Needs help with all home maintenance tasks.

5. LAUNDRY

- A. Does all personal laundry.
- B. Launders small items . rinses socks, stockings, etc.
- C. Is unable to do laundry for self.

6. TRANSPORTATION

- A. Travels independently on public transportation or drives own car.
- B. Arranges own transportation via taxi but does not otherwise use public transportation.
- C. Travels on public transportation when assisted/accompanied by another person.
- D. Travel is limited to taxi or car with assistance of another.
- E. Does not travel at all.



Applicant's Name _____ Date _____

7. MEDICATIONS

- A. Is responsible for taking own medication in correct dosages and at correct time.
- B. Is responsible for taking medication when it has been prepared in advance in separate dosages by another person
- C. Is not capable of dispensing or taking own medication independently.

8. FINANCES

- A. Manages financial matters independently; collects and keeps track of own income and bills.
- B. Manages day to day purchases but needs help with major purchases and banking.
- C. Can manage a monthly or weekly allowance.
- D. Is not capable of handling money.

REASON FOR CHANGING RESIDENCE

1. Contact with family members? yes no
Where do family members reside? _____
Frequency of contact with family members:
 Daily Weekly Monthly Annually
Nature of contacts:
 Visits Phone Mail Other _____
2. Contact with friends? yes no
Where do friends reside? _____
Frequency of contact with family members:
 Daily Weekly Monthly Annually
Nature of contacts:
 Visits Phone Mail Other _____
3. Expresses dissatisfaction with current living situation? yes no
If YES, please list reasons: _____
4. Ability to leave current home: yes no
Frequency: Daily Weekly Monthly Annually
Reasons: _____
5. Fear of living alone: yes no
Reasons and/or nature of fear: _____

6. Additional comments or pertinent information:



Applicant's Name _____ Date _____

HEALTH INFORMATION FOR APPLICANT

Were you ever treated for:

Yes	Name Condition	When	Hospitalized	Where	When
<input type="checkbox"/>	Cardiac Condition	_____	_____	_____	_____
<input type="checkbox"/>	Circulatory Problem	_____	_____	_____	_____
<input type="checkbox"/>	Stroke/TIA	_____	_____	_____	_____
<input type="checkbox"/>	Glandular Problem	_____	_____	_____	_____
<input type="checkbox"/>	Arthritis	_____	_____	_____	_____
<input type="checkbox"/>	Genito-Urinary	_____	_____	_____	_____
<input type="checkbox"/>	Nervous System	_____	_____	_____	_____
<input type="checkbox"/>	Vision Problems	_____	_____	_____	_____
<input type="checkbox"/>	Hearing Problems	_____	_____	_____	_____
<input type="checkbox"/>	Mental/Emotional	_____	_____	_____	_____
<input type="checkbox"/>	Cancer	_____	_____	_____	_____
<input type="checkbox"/>	Back Pain	_____	_____	_____	_____
<input type="checkbox"/>	Diabetes	_____	_____	_____	_____
<input type="checkbox"/>	Digestive Problems	_____	_____	_____	_____
<input type="checkbox"/>	Other	_____	_____	_____	_____

Have you ever had:

- Blackouts Convulsions/Seizures Feeling of Anxiety Headaches
- Forgetfulness Fear of Hurting Self Depression Tremors
- Crying Spells Fear of Hurting Others Dizziness Loneliness
- Fatigue Feelings of Inadequacy Other _____

Please list all allergies: _____

Medications:

Name:	Dosage:	Prescribed For:
_____	_____	_____
_____	_____	_____
_____	_____	_____

Health Insurance:

Medicare # _____ Medicaid # _____

Other Insurance Provider: _____ Policy # _____