Blue Horizon
Boutique Assisted Living & Memory Care

APPLICATION FOR RESIDENCY & HEALTH HISTORY

Today's Date:_____ Referred to us by:_____ _____

Completed by:_____ Relationship to Resident:_____

Room Preference (Circle One) Private Semi-Private Price Quoted_____ for Room #:_____

Potential Move-in Date:_____
A non-refundable $500 deposit can be given to hold the room for one week. This amount does NOT go towards the first month's rent. A community fee of $1000 is required upon move in.

Location Preference: (Check One) ☐ Tender Heart ☐ Westridge Village ☐ Robin House ☐ Casa del Norte

GENERAL RESIDENT INFORMATION:

Resident Name: _____ _____ Gender: ☐ M ☐ F

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widow(er)

Date of Birth:_____ Age:_____Height:_____Weight:_____

Resident's Current Location: _____
(Location where assessment is to be completed)

Next of Kin/Resident Representative Name:_____

Contact #:_____ E-mail:_____

Is resident eligible for Veteran's Benefits? ☐ Yes ☐ No ☐ Unknown

Does resident have Long Term Care Insurance? ☐ Yes ☐ No

Is resident a Medicaid/Centennial Care Recipient? ☐ Yes ☐ No

If yes, Name of MCO and Member #:_____

HEALTH INFORMATION

Primary Care Physician's Name:_____Phone #:_____

Other Physician's Name:_____Specialty_____

Other Physician's Name:_____Specialty:_____

HEALTH CARE SERVICES

Has the resident received any services from agencies such as home health or hospice in the last 6 months ?

If so, please list the name of the company:_____

Reason:_____Dates:_____

Allergies to Food and/or Medications:_____

Describe any physical limitations the resident presently has:_____

_____

In order for us to ensure the resident will be an appropriate placement, please circle any medical equipment / assistive devices currently used including, but not limited to, wheelchair, walker, hearing aids, dentures, hoyer lifts, geri chairs:
Other: _____

Describe any cognitive limitations the resident presently has: _____

_____

List any illnesses, including mental or emotional, the resident presently has or has been treated for in the past two years:

_____

Date of Last Hospitalization:_____Reason:_____

Has the resident been in a nursing home, assisted living, or any other type of long term care facility in the last year?

If so, where:_____

What was the reason for leaving?_____

Does the resident have a Power of Attorney, Trustee, or anyone else who handles his/her financial affairs? Yes No

If yes, name/relationship of responsible person:_____

Approximately Length of Stay/Services Requested: ☐ 1-3 months ☐ 3-6 Months ☐6 Months +

Other:_____

If less than six months, please explain: _____

Please use the space below to tell us what is important to you regarding the care of your loved one and what you are looking for in an assisted living community:

_____

_____

_____ _____

Resident, Relative, or Representative Date

If you are interested in moving forward with admission to one of our communities, please complete and return this application to the location where you toured, or fax to 800-557-3574 or e-mail to tayers.apal@gmail.com. Upon receipt, we will contact you to set up the next steps.

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information (Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

1. Authorization** I authorize ***Preferred Assisted Living, Inc.,*** (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare for all past, present, and future periods.

3. Extent of Authorization

a. I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until I revoke it.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal
Representative and his/her relationship to patient

_____ _____

Signature of Witness Date

_____

Printed Name of Witness and Facility Witness
Represents

PLEASE FAX REQUESTED RECORDS TO 800-656-0960 *OR* E-MAIL TO LYNNE.BLAKE@GMAIL.COM