Please Print or Type

Emma Cares, Inc.
Senior and Community Services

Independent Living

Personal Information

Name: _____
Last First Middle

Address: _____
Number and Street

_____
City State Zip Code

Telephone Number: (___)_____ Sex: ❑ Male ❑ Female

Social Security # _____ Religion_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed-How Long_____

Date of Birth_____ Place of Birth_____

Occupation if applicable: _____ Employer: _____

Employer Address: _____ Phone: (____)_____

Medical Information

Physician Name: _____

Address: _____
Street City State Zip

Telephone # (___)_____ (___)_____

List any illnesses or ailments, including emotional, you presently have or have been treated for, in the past two years:

_____

_____

Date of last hospitalization_____ Reason: _____

Please Print or Type

Have you ever received psychiatric treatment: ❑ Yes ❑ No

Have you ever resided in another independent living, assisted living, and nursing facility? ❑ Yes ❑ No

Which Facility: _____

Periods of Stay: From: _____ To: _____

Why did you leave that facility? _____

Emergency Contact Information

Contact Name: _____ Relation: _____

Address: _____

Street City State Zip

Telephone # (___)_____Home (___)_____Work

Contact Name: _____ Relation: _____

Address: _____

Street City State Zip

Telephone # (___)_____Home (___)_____Work

Contact Name: _____ Relation: _____

Address: _____

Street City State Zip

Telephone # (___)_____Home (___)_____Work

Legal Representatives

Does anyone handle your financial affairs? ❑ Yes ❑ No

If Yes, Who? _____ _____

Name Relation

Referral Source

How did you hear about our facility? _____

Insurance Information

Medicare #_____

Other Health Insurance # _____ Name: _____

Telephone #_____

Life Insurance Name: _____ Beneficiary: _____

Approximate value: _____ Face value: _____

Please Print or Type

Financial Information:

Monthly Income: Please enter Monthly Gross Amount

Social Security: _____ Pension: _____

Annuity: _____ Other: _____

Do you receive any rental income ❑ Yes ❑ No, Monthly Amount: _____

Driving

Do you have a current, valid driver's license? ❑ Yes ❑ No

Are you presently operating a vehicle? ❑ Yes ❑ No

Do you plan on having an automobile at our facility? ❑ Yes ❑ No

Authorization

Everything stated in this application is true and correct.

Please note that care is not covered by Emma Cares, Inc.

Signature of person completing application: _____

Date: _____

Thank you for considering Emma Cares as your next home!

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