



We are pleased that you have chosen to apply to become a resident of the **Wye Valley Apartments at The British Home**. If you have any questions about this application packet, please contact either Lisa Capone or Amy Selle in the Marketing office at **(708) 485-1155** and we will be glad to assist you.

To reserve your apartment, please submit your \$100 Application Fee. You will be required to pay a refundable security deposit equal to one month's rent.

Step 1: Please complete and return the following documents contained in this packet:

- _____ Application for Residency
- _____ Financial Statement
- _____ Notice of Privacy Practices Acknowledgment Form

Step 2: Once the above documents are received and reviewed by us, we will ask you to contact your personal physician to schedule a physical examination. Your physician must complete the enclosed Physician's Report. If you have seen your physician within the last 90 days, he or she can complete the form without scheduling a new appointment.

We look forward to you becoming a member of the family here at The British Home Community, and we are glad you have selected the Wye Valley Apartments as your new home.

Thank you,
The Marketing Staff of The British Home



The British Home

Your Personal Retirement Community

8700 West 31st Street, Brookfield, Illinois 60513-1097
708-485-1155 Fax: 708-485-8830 www.thebritishhome.org
A not-for-profit organization, and a smoke-free campus

Application for Residency

Please print or type in permanent ink. The information contained in this application will be kept confidential and used solely for the purposes of The British Home Community.

I hereby make application to the following (please check one):

- Wye Valley (Independent Living)** Circle apartment size preference: 1BR Larger 1BR 2BR
 The Woodlands (Assisted Living) Circle apartment size preference: Studio 1BR 2BR
 The Laurels (Private Sheltered Care Studios)
 Medicare Rehabilitation/Skilled Nursing **Health Care Center (Private Pay)**

APPLICANT:

Last Name	First Name	Middle Name		
		()		
Street Address	City	State	Zip Code	Telephone
Social Security Number	Medicare Number (or comparable railroad insurance number)			
Date of Birth	Birthplace			
Number of years at present address: _____				
Present living arrangement (circle appropriately): Own Home Own Condo/Townhouse Rent Live with Family Other				
If other, explain: _____				
Marital status (circle appropriately): Never Married Married Widowed Separated Divorced				
Are you a citizen of the U.S.? (circle) Yes No Are you a veteran? (circle) Yes No				
Race/Ethnicity (circle): American Indian/Alaskan Native Asian/Pacific Islander Black, not Hispanic Hispanic White, not Hispanic Other: _____				
Primary Language Spoken: _____				

Name of Father: _____ Birthplace: _____

Maiden Name of Mother: _____ Birthplace: _____

SPOUSE:

Name

Maiden Name

PREVIOUS OCCUPATION/EDUCATION**Most recent occupation:**

Company

Position

Education (Mark highest level completed)

No schooling 8th grade/less 9-11 grades High school

Technical or trade school Some college Bachelor's degree Graduate degree

PASTORAL CARE

What is your religious affiliation (denomination) if any? _____

Of what church are you a member? _____

_____ (_____) _____
Clergy Contact Telephone Number

Church Street Address

City

State

Zip Code

Do you wish Clergy to be called in case of emergency? (circle) Yes No No Preference

Do you have any prearranged funeral arrangements? _____

INSURANCE

Do you have Supplemental Health Insurance? (circle) Yes No

Policy Name

Group Number

ID Number

Do you have Long Term Care Insurance? (circle) Yes No Policy Name: _____

ADVANCE DIRECTIVES

Do you have a Living Will? Yes No **Please attach copy**

Do you have Durable Powers of Attorney?

for Healthcare? Yes No **Please attach copy**

for Property/Finances? Yes No **Please attach copy**

CONTACTS IN CASE OF EMERGENCY (Please list in the order of how they will be called):

1) _____

Name	Relationship		
Street Address	City	State	Zip Code
Home Phone #	Work Phone #	Cell Phone #	E-mail

2) _____

Name	Relationship		
Street Address	City	State	Zip Code
Home Phone #	Work Phone #	Cell Phone #	E-mail

3) _____

Name	Relationship		
Street Address	City	State	Zip Code
Home Phone #	Work Phone #	Cell Phone #	E-Mail

MEDICAL INFORMATION

Name of Primary Care Physician	Office Phone Number	Hospital Affiliation	
Street Address	City	State	Zip Code

Name of Other Physician	Office Phone Number	Hospital Affiliation	
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Street Address	City	State	Zip Code
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Name of Dentist	Office Phone Number	Hospital Affiliation	
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Street Address	City	State	Zip Code
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Your Hospital Preference: _____

PERSONAL INFORMATION

If bills should be sent to someone other than the resident, please identify person below:

Name	Relationship
------	--------------

Street Address	City	State	Zip Code
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Home Phone #	Work Phone#	Cell Phone #	E-mail
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Do you plan to bring any automobiles? Yes No If yes, please complete the following:

Make _____ Model _____ Year _____ Color _____ License Plate Number _____

I hereby certify to the best of my ability that the above information is correct.

Applicant's Signature

Date

PLEASE NOTE: It is the policy of The British Home to complete a standard criminal background/sexual offender check on all persons making application to the Health Care and Medicare Rehabilitation Center or the Laurels Sheltered Care sections of The British Home campus. The background check is done by comparing the applicants' names to state/federal databases. *Revised: 11/2007*



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Financial Application

(Please complete with "total" values on the line items. There is no need to list or detail every account.)

Assets:

Checking Accounts _____

Savings Accounts _____

Other _____
(Including money market, CDs, etc.)

Equities (at market) _____

Fixed Securities _____
(Bonds, treasury notes, annuities, etc.)

Real Estate _____
(Less mortgage owed)

Life Insurance in Force:

Term Insurance _____

Whole, Variable, Universal Life:

Cash Value _____

Face Value _____

Liabilities:

Bank Loans _____

Credit Card Balances _____

Other Debts _____

Monthly Income:

Social Security _____

Pension _____

Other _____

Please submit copies of bank statements and if possible portfolio summary.

AFFIDAVIT OF APPLICANT

I hereby certify, to the best of my ability, that the answers to the foregoing questions are true and correct and that the listed assets will be available and used to pay for my stay at The British Home. I hereby authorize The British Home to seek verification of all financial information.

Signed: _____

Date: _____

Print Name: _____



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Providing: Independent and Assisted Living, Sheltered Care, Intermediate Care, and Skilled Nursing/Rehabilitation

Physician's Report

Patient Name: _____ Phone Number: _____

Address: _____

Date of Birth: _____ Date of Physical Examination: _____

Purpose of Assessment: ___ Prior to Admission ___ Annual ___ Significant Change in Condition

Past Medical History – Check appropriate. List details below. Include type/date of surgery.

- | | | |
|----------------------|------------------------|--------------------|
| ___ Hypertension | ___ Positive PPD | ___ Diabetes |
| ___ Stroke | ___ Surgery | ___ Mental Illness |
| ___ G.I. Problems | ___ Anemia | ___ Depression |
| ___ Respiratory/COPD | ___ Arthritis | ___ HIV/AIDS |
| ___ Carcinoma | ___ Allergic Reactions | ___ Heart Disease |
| ___ T.B. | ___ Drug/Alcohol Abuse | ___ Dementia |

Summary of Present or Chronic Diseases: _____

Allergies: _____

Flu Shot-Date _____ **Pneumovax-Date** _____ **Facility may do 2-step Mantoux** ___ Yes ___ No

Social History/Habits: _____

Medications: _____

Physical Examination:

Weight (last year): _____ Height: _____ Temp: _____ Pulse: _____
Weight (Present): _____ Resp: _____ Blood Pressure: _____

HEENT: _____ Chest/Lungs _____

Abdomen: _____

Genitourinary: _____

Extremities: _____

Skin: _____

Neurological: _____

Musculoskeletal: _____

Is this person free from any obvious communicable diseases? Yes No

Based on my assessment, the resident warrants assistance with the following ADL's:

ACTIVITY OF DAILY LIVING (ADL)	YES	NO	EXPLANATION
Eating			
Does resident have any special dietary needs?			
Dressing			
Toileting			
Transferring			
Bathing			
Personal Hygiene			

Medication Questionnaire:

MEDICATION MANAGEMENT	YES	NO	EXPLANATION
Can resident administer his/her own medication?			
Does resident require supervision when taking medications?			
Does resident require establishment personnel to administer medication?			

Assessment/Recommendation: _____

Check appropriate level of care: Assisted Living Skilled Nursing Independent Living
 Sheltered Care Intermediate Care

Physician's Signature/Certification

Address

(Please print or type Physician's name here)

City State Zip

() _____
Phone Number