EBENEZER APPLICATION FOR RESIDENCY

Please provide all the requested information, sign and initial as noted, and return to Facility.

Apartment Preference: ☐ Independent Living ☐ Assisted Living ☐ Memory Care
☐ Enhanced Care (if applicable)

Date I wish to move in, if accepted: _____ Apartment # _____

We are a smoke free and tobacco free building and property. We prohibit smoking and tobacco use in all indoor and outdoor areas.

Applicant is a: ☐ Smoker ☐ Non-smoker

FIRST APPLICANT INFORMATION

Applicant Full Name - Last, First, Middle		Date of Birth
Applicants Preferred Name		
Present Address	Phone #	Social Security Number
City	State	Zip Code
Email	Veteran? Yes ☐ No ☐ Branch _____ Spouse of a Veteran? Yes ____ No _____	
If storing vehicle at community, complete fields below		
Make/Model of Vehicle	Vehicle Color	
License Plate	Driver's License number	

SECOND APPLICANT INFORMATION (If Applicable)

Applicant Full Name - Last, First, Middle		Date of Birth
Applicants Preferred Name		
Present Address	Phone #	Social Security Number
City	State	Zip Code
Email	Veteran? Yes ☐ No ☐ Branch _____ Spouse of a Veteran? Yes ____ No _____	

DESIGNATED REPRESENTATIVE/EMERGENCY CONTACT INFORMATION

If Resident declines to name a Designated Representative, Resident to initial here:_____

Priority Contact One

Name	Relationship	
Address	City/State	Zip Code
Telephone Number ☐ Home ☐ Cell ☐ Work	Email:	

You have the right to name anyone as your "Designated Representative." A Designated Representative can assist you, receive certain information and notices about you, including some information related to your health care, and advocate on your behalf.

A Designated Representative does not take the place of your guardian, conservator, power of attorney ("attorney-in-fact"), or health care power of attorney ("health care agent"), if applicable. This may be the same individual as the legal representative if you choose.

Resident has the right, at any time, to add, remove, or change the name and contact information of Resident's Designated Representative.

If we are unable to reach your designated representative in an emergency situation, please provide an additional contact below:

Priority Contact Two

Name	Relationship	
Address	City/State	Zip Code
Telephone Number ☐ Home ☐ Cell ☐ Work	Email:	

Please note in the event of an emergency, we will attempt to notify your designated representative first and if we are unable to reach your designated representative, we will attempt to contact your second contact. It is expected that your designated representative/second contact update others per your preference.

**I understand that these authorizations will continue through my residency at Facility if I become such a resident, unless I void such authorizations in writing.

LEGAL REPRESENTATIVE/EMERGENCY CONTACT INFORMATION

Legal Representative (**supporting documentation required**) If documentation is not provided, the information provided below will not be honored. If you have more than one legal representative, please attach the below contact information to this application.

Priority Contact One

Name	Relationship	
Address	City/State	Zip Code
Telephone Number ☐ Home ☐ Cell ☐ Work	Email:	
☐ Health Care Agent ☐ Financial Power of Attorney ☐ Conservator/Guardian		

FINANCIAL INFORMATION

INCOME INFORMATION: List the total of all sources of fixed income e.g., social security, retirement funds, pension, disability, alimony, annuities, SSI, public assistance (attach additional page if needed)

SOURCE (from whom)	AMOUNT	How often is income received?
	$	
	$	
	$	
	$	
	$	
	$	

ASSETS: List the total of all assets, value, and interest on checking /savings accounts, CDs, annuities, money market funds, savings bonds, stock, mutual funds, real estate (attach additional page if needed)

TYPE OF ASSET	VALUE OF ASSET	INTEREST/DIVIDEND RECEIVED
	$	
	$	
	$	
REAL ESTATE	**$**	
TOTAL ASSETS	**$**	

RENTAL INFORMATION

Please list any rental information for the last 5 years (attach additional page if needed)
If you have owned your home for the past 5 years, **please check here ☐ and go on to the next section.**

Name of Present Landlord	Telephone Number	
Address	Dates you have lived at present address FROM: TO:	
City	State	Zip Code
Reason for leaving:		

FIRST APPLICANT HEALTH CARE INFORMATION

*** *Required for Assisted Living, Memory Care and Enhanced Care Residents****

Please list your provider for each professional service below (attach additional providers as needed)

Medicare Number	Medicaid Number
Primary Clinic	Telephone Number
Primary Physician	Telephone Number
Hospital	Telephone Number
Pharmacy	Telephone Number
Home Health Care	Telephone Number
Other Health Care Provider	Telephone Number

By initialing each line below, I authorize Facility to contact the above-named person(s) and organizations for the following purposes:

_____ To release or disclose to Facility and/or its designee all medical records or other information regarding any treatment, inpatient and/or outpatient care I have received from such health provider

_____ To use facsimile copy or photo copy of this form to send to health providers as a release of information

**I understand that this authorization, except for action already taken, may be voided by me at any time in writing and will expire in any event in one year.

SECOND APPLICANT HEALTH CARE INFORMATION (IF APPLICABLE)

*** *Required for Assisted Living, Memory Care and Enhanced Care Residents ****

Please list your provider for each professional service below (attach additional providers as needed)

Medicare Number	Medicaid Number
Primary Clinic	Telephone Number
Primary Physician	Telephone Number
Hospital	Telephone Number
Pharmacy	Telephone Number
Home Health Care	Telephone Number
Other Health Care Provider	Telephone Number

By initialing each line below, I authorize Facility contact the above-named person(s) and organizations for the following purposes:

_____ To release or disclose to Facility and/or its designee all medical records or other information regarding any treatment, inpatient and/or outpatient care I have received from such health provider

_____ To use facsimile copy or photo copy of this form to send to health providers as a release of information

**I understand that this authorization, except for action already taken, may be voided by me at any time in writing and will expire in any event in one year.

RELEASE INFORMATION

I certify that all information contained in this application is true and accurate to the best of my knowledge. I authorize release of any and all information in this application to **Facility** and/or its designee.

Information gathered in the application will be used to complete a background check. By signing this application, I authorize Rental History Reports (RHR) / 701 South Fifth Street, Hopkins, MN 55343 to investigate my criminal history, rental, employment and income history for the purpose of housing. The source of the information may come from but is not limited to: credit bureaus; banks and other depository institutions; federal or state records including State Employment Security Agency records: county or state criminal records or other sources as required. It is understood that a photocopy or facsimile copy of this form will serve as authorization. I understand failure to complete this form completely and truthfully may result in denial and/or forfeiture of deposit. This authorization is for this transaction only and continues in effect for one (1) year unless by state law, in which case the authorization continues in effect for the maximum period, not to exceed one (1) year, allowed by law.

_____ _____

Signature 1st Applicant/Representative Date

Printed Name	Relationship

_____ _____

Signature 2nd Applicant/Representative Date

Printed Name	Relationship

The Senior LinkAge Line® is a free service of the state of Minnesota that connects older Minnesotans and their families with the help they need. Visit the website https://www.seniorlinkageline.com or call 1-800-333-2433 (Monday - Friday, 8:00am - 4:30pm). Topics include Medicare, Prescription Drug Expense Assistance, Care Transitions, Long-Term Care Options, Health Care Fraud and Abuse, and help with filling out government applications and forms.

For internal use only:

Received by: _____ Date: _____