



7125 Fauntleroy Way SW
 Seattle, WA 98136-2008
 (206) 937-2800
 (206) 933-2795 fax

Application for Residency

I am applying for:

- Kenney Standard Program
- Kenney Monthly Program
- Ballymena Program
- Assisted Living Program

Your Personal Information

Last Name: _____ First Name: _____ MI: _____
 Address: _____
 City: _____ State: _____ Zip code: _____ Phone: _____
 Birthdate: _____ Current Age: _____ Birthplace: _____
 Marital Status: _____ Maiden Name: _____
 Language: _____ Religious Preference: _____
 Military: _____ Citizenship: _____ Social Security: _____

Insurance Information— Please provide your insurance cards to be copied

Primary Insurance: _____ Policy Number: _____
 Secondary Insurance: _____ Policy Number: _____
 Medicare #: _____ Circle: Medicare A; Medicare B; Medicare D; Dental Benefits

Your Knowledge of The Kenney

How did you hear of The Kenney? (Mark all that apply.)

- | | | |
|---|---|---|
| <input type="checkbox"/> West Seattle Herald Ad | <input type="checkbox"/> Yellow Pages Ad | <input type="checkbox"/> Over 50 & Fit |
| <input type="checkbox"/> Church Presentation | <input type="checkbox"/> Family Member | <input type="checkbox"/> Friend is a Resident |
| <input type="checkbox"/> Board Member | <input type="checkbox"/> Community Referral | <input type="checkbox"/> Our Web Site |
| <input type="checkbox"/> Other _____ | | |

List Residents of The Kenney whom you know, if any: _____

Your Personal History and Interests

List your hobbies and interests: _____

What types of transportation do you use? _____

Your Move into The Kenney

Explain your interest in moving into The Kenney. What are the key reasons for your move into a Continuing Care Retirement Community? _____

The Kenney is a community of diverse individuals with many different interests. Describe how you would interact with your neighbors on a daily basis. _____

Your Health

Please assess your current health and check appropriate responses in all categories:

VISION

- I have no problems
- My sight impairs activity
- Blind: Left Eye Right Eye
- I wear corrective lenses or glasses
- I have or had cataracts Left Right

DRESSING

- I require no assistance
- I require some assistance with dressing
- I require full assistance with dressing

DIET

- General
- Salt-restricted
- Diabetic
- Other _____

EATING

- I eat independently
- I require meat to be cut
- I must be fed
- I have dentures: Lower Upper
- I have partials: Lower Upper
- I have an eating or swallowing problem
- Describe: _____

MENTAL STATUS

- I am alert and oriented
- I am forgetful of recent events
- I am forgetful of past events
- I am confused
- I am anxious
- I am depressed/withdrawn
- I am unable to communicate my needs

HEARING

- Adequate for communication
- I am very hard of hearing
- I am deaf
- Hearing aids: Left Right

SLEEP

- I sleep through the night
- I wander at night
- I am noisy at night

BATHING

- I prefer a shower
- I prefer a bath
- I need some assistance with bathing/showering
- I require total assistance

BOWEL AND BLADDER

- I have no problems
- I have occasional accidents
- I dribble
- I lack control of my bowel
- I lack control of my bladder
- I have a colostomy
- I have a catheter

BEHAVIOR

- I have no problems
- I manage with prompting
- I wander
- I am combative
- I am often noisy
- I am unable to socialize

ABILITY TO WALK

- I walk independently
- Independently w/ Walker Cane
- I need stand-by assistance w/walking
- Weight-bearing during transfer with Assistance of one two people
- I am non-weight-bearing

Professional Contact Information (Please include complete name and address of each.)

Primary Physician: Name: _____
Address: _____
Telephone: _____

Alternate Physician: Name: _____
Address: _____
Telephone: _____

Dentist: Name: _____
Address: _____
Telephone: _____

Eye Doctor: Name: _____
Address: _____
Telephone: _____

Funeral Home: Name: _____
Address: _____
Telephone: _____

Hospital of Choice: Name: _____
Address: _____
Telephone: _____

Pharmacy of Choice: Name: _____
Address: _____
Telephone: _____

Personal Contact Information (Please include complete name and address of each.)

Emergency Contact: Name: _____
Address: _____
Telephone: _____

Power of Attorney
of Financial: Name: _____
Address: _____
Telephone: _____

Power of Attorney
of Health Care: Name: _____
Address: _____
Telephone: _____

Other: Name: _____
Address: _____
Telephone: _____

Other: Name: _____
Address: _____
Telephone: _____

Medical History

Please circle all conditions you have ever had or do have now:

- | | | |
|---------------------------|----------------------|-----------------------|
| Anemia | Eczema | Neuralgia |
| Angina | Eye Disease | Neuritis |
| Anxiety | Eye Injury | Overweight |
| Appendicitis | Heart Attack | Pacemaker |
| Arthritis | Heart Disease | Polio |
| Asthma | Hepatitis | Pneumonia |
| Bladder Infection | High Blood Pressure | Psoriasis |
| Bone or Joint Replacement | Influenza | Rheumatic Fever |
| Bursitis | Irregular Heartbeats | Sciatica |
| Cancer | Jaundice | Seizures |
| Chicken Pox | Kidney Stones | Severe Headaches |
| Depression | Lumbago | Shingles |
| Diabetes | Measles | Stroke |
| Diphtheria | Memory Problems | Swallowing Difficulty |
| Ear Disease | Mumps | Tremors |
| Ear Injury | Nervous Breakdown | Tuberculosis |

Other conditions not listed above: _____

Do you use alcoholic beverages? ___ Yes ___ No Tobacco? ___ Yes ___ No

Allergies

Are you allergic to:

Penicillin ___ Sulfa ___ Aspirin ___ Codeine ___

Morphine ___ Anesthetics ___

Other Drug(s) _____

Food Allergies _____

Do you have any special diet needs? Yes No

If yes, please list: _____

Surgery & Hospitalizations

When, where and what for: _____

Have you ever had a blood or plasma transfusion? If so, when? _____

Current Medications

Please list the drug's name, strength, how often the drug is taken, and what for. Please include over the counter medications such as aspirin, non-aspirin, vitamins, laxatives, antacids, etc.

Current Health

Please list any concerns you have about your health _____

I certify that the information provided in this application for Residency is completed and correct to the best of my knowledge, and that no information has been withheld.

Your Signature: _____ Date: _____

Statement of Your Financial Resources

The following information is to be completed as accurately as possible.

ASSETS

Real Estate \$ _____
Investments \$ _____
Savings Account \$ _____
Other _____ \$ _____
Total Assets

LIABILITIES

Mortgage(s) \$ _____
Credit Card Debt \$ _____
Other _____ \$ _____
Other _____ \$ _____
Total Liabilities

MONTHLY INCOME

Retirement Accounts(s) \$ _____
Pension \$ _____
Social Security \$ _____
Other _____ \$ _____
Total Monthly Income

Long Term Care Insurance: *Please list all policies and policy numbers* _____

Financial Disclosure Statement

I hereby declare that all financial statements made herein are true and completed according to the best of my knowledge and belief. It is my understanding that acceptance into The Kenney is based on this financial statement.

Signature: _____ Date: _____