CarlylePlace
NavicentHealth

APPLICATION FOR RESIDENCY

Full Name _____ Spouse (If applying jointly) _____

Nickname _____ Secondary SSN _____

Primary SSN _____ Relationship status _____ Anniversary Date (If applying jointly) _____

Place Of Birth _____ Date of Birth _____ ◯ Male ◯ Female

Address _____ City _____ State _____ Zip Code _____

Years at current address _____ Where have you lived most of your life? _____

Phone _____ E-mail Address _____ Mobile _____

Education Level: _____ School Name: _____ Secondary Language _____

Business/ Profession _____ Retirement Date _____ Retirement Status _____

List Civic, Fraternal, Professional, Academic, or other Organizations/Boards of which you serve or have served:

What are your special interest, hobbies, or skills?

What new interest/hobbies would you like to develop?

Vehicle Year _____ Vehicle Make _____ Vehicle Model _____ Vehicle Color _____

Registered Voter _____ War Veteran (Which War) _____ Military Branch _____ Citizen of _____

Religious Information (OPTIONAL)

Place of Worship _____

Denomination _____ Clergy _____

City _____ State _____ Zip Code _____ Phone _____

Personal Contacts

Please list your children or other close relatives.

List primary contact first.

Full Name | Relationship | Phone | Mobile

Address | City | State | Zip Code

Power Of Attorney Please check all that apply: ☐ Health ☐ Legal ☐ Financial | E-mail Address

Full Name | Relationship | Phone | Mobile

Address | City | State | Zip Code

Power Of Attorney Please check all that apply: ☐ Health ☐ Legal ☐ Financial | E-mail Address

Full Name | Relationship | Phone | Mobile

Address | City | State | Zip Code

Power Of Attorney Please check all that apply: ☐ Health ☐ Legal ☐ Financial | E-mail Address

REFERENCES: Please list (3) three people who we may contact for further information.

Full Name | Relationship | Phone

Address | City | State | Zip Code

Full Name | Relationship | Phone

Address | City | State | Zip Code

Full Name | Relationship | Phone

Address | City | State | Zip Code

Please tell us briefly, why you chose Carlyle Place?

I affirm that the information contained in this Application for Residency is correct and substantially complete to the best of my knowledge.

Signature

Date

CarlylePlace
NavicentHealth

CONFIDENTIAL HEALTH HISTORY

Full Name _____ Date _____

In your own words, briefly describe your health:

Family History _____ Maiden Name _____

Father's Name _____ Father's Birthplace _____

Mother's Name _____ Mother's Birthplace _____

Height _____ Weight _____ Date Of Birth _____

Specify any limitations (Vision, Hearing, Climbing Steps, Driving, Walking, ETC)

Mobility Needs: ☐ Motorized Ambulatory Aid ☐ Walker ☐ Cane ☐ Wheelchair ☐ NONE

Vision: ☐ Glasses ☐ Contacts **Dentures:** ◯ Upper ◯ Lower ◯ Partial ◯ NONE

Hearing: ◯ Hearing Aid (Left Ear) ◯ Hearing Aid (Right Ear) ◯ Both ◯ NONE

☐ Pacemaker ☐ Prosthesis ☐ Internal Met

Brand _____ Describe _____ Describe _____

Have you ever been treated for any of the following? (Give approximate year of onset and brief explanation)

Alcoholism/Drug Addiction	◯ NO	◯ YES	Year		Comments	
Alzheimer's/Dementia	◯ NO	◯ YES	Year		Comments	
Anemia	◯ NO	◯ YES	Year		Comments	
Cancer	◯ NO	◯ YES	Year		Comments	
Communicable Blood Disorders	◯ NO	◯ YES	Year		Comments	
COPD (Emphysema, Chronic Bronchitis, Asthma)	◯ NO	◯ YES	Year		Comments	
Depression	◯ NO	◯ YES	Year		Comments	
Diabetes	◯ NO	◯ YES	Year		Comments	
Heart Attack/Heart Disease	◯ NO	◯ YES	Year		Comments	
Kidney Disease	◯ NO	◯ YES	Year		Comments	
Lou Gehrig's/ALS	◯ NO	◯ YES	Year		Comments	
Multiple Sclerosis	◯ NO	◯ YES	Year		Comments	
Parkinson's Disorder	◯ NO	◯ YES	Year		Comments	
Polio	◯ NO	◯ YES	Year		Comments	
Psychiatric Disorder	◯ NO	◯ YES	Year		Comments	
Stroke	◯ NO	◯ YES	Year		Comments	

Specify any special diet requests

Describe major surgical operations, serious illness, or hospitalization (include approximate year)

Food Allergies

Medical Allergies

Medications with dosage

Date of last Tetanus Date of last Pneuma Date of last Flu

Describe if under medical care

Are you covered by Medicare? ◯ **NO** ◯ **YES** ◯ **Part A** ◯ **Part B** Medicare Number

Medicare Equivalent

Carrier's Name *Supplemental* Policy Benefit

Carrier's Name *Long Term Care* Policy Benefit

Carrier's Name *Other* Policy Benefit

Primary Physician(s) and Specialists

Full Name Phone Type:

Address City Zip Code

Full Name Phone Type:

Address City Zip Code

Full Name Phone Type:

Address City Zip Code

Full Name Phone Type:

Address City Zip Code

Living Will Allow Natural Death (DNR) Health Care Surrogate

Organ Donor Funeral Home Burial Info

Do you presently have assistance in your home? If yes, please list their names and types of assistance provided.

Additional remarks

I affirm that the information contained in this Confidential Health History is correct and substantially complete to the best of my knowledge

Signature Date

CarlylePlace
NavicentHealth

CONFIDENTIAL FINANCIAL STATEMENT

Full Name _____ Spouse Name (If applying jointly) _____

Primary SSN _____ Secondary SSN _____

Primary Date Of Birth _____ Secondary Date Of Birth _____

Address _____ City _____ State _____ Zip Code _____

Annual Income

Social Security _____	Interest _____	Annuity _____
Spouse Social Security _____	Real Estate Income (Please describe below) _____	Dividend _____
Survivorship Percentage _____	Pension _____	**Total Income** _____

Assets

Cash *(On hand and In Banks)* Attach Bank Statement _____	Accounts & Notes Receivable _____
Stocks & Securities (Provide Brokerage Statement) _____	Real Estate Owned Market Value _____
Life Insurance (Cash Value) _____	Property Address _____
	Property Titled To _____
Certificates of Deposit Attach Bank Statement _____	**Total Assets** _____

Liabilities

Other Debts (Itemize)	Notes Payable to Bank _____
Credit Card	Notes Payable to Others _____
◯ Master Card ◯ Visa _____	Mortgages Payable (See Schedule) _____
◯ AE ◯ Discover _____	Accounts & Bills Due (See Schedule) _____
_____ _____	**Total Liabilities** _____
_____ _____	

Please describe any other assets or liabilities not already listed.

Long Term Care Insurance (Primary)		Long Term Care Insurance (Secondary)	
Benefit Period (In Years)		Benefit Period (In Years)	
Elimination Period (In Days)		Elimination Period (In Days)	
ALU Daily Benefit		ALU Daily Benefit	
NCU Daily Benefit		NCU Daily Benefit	
Inflation Adjusted	◯ YES ◯ NO	Inflation Adjusted	◯ YES ◯ NO
Annual Premium		Annual Premium	
Premium Inflation %		Premium Inflation %	

SCHEDULE OF LIFE INSURANCE CARRIED, INCLUDING GROUP INSURANCE

Company	Amount	Beneficiary	Cash Surrender Value	Loan Amount

CONFIDENTIAL FINANCIAL STATEMENT

Schedule of U.S. Government Securities, listed and unlisted securities, and other stocks and bonds owned (if more space needed please attach additional sheet)

I affirm that the information contained in this Confidential Financial Statement is correct and substantially complete to the best of my knowledge.

Signature

Spouse Signature

Date

Date

Please return completed information to

Carlyle Place,
Navicent Health
5300 Zebulon Road
Macon, Georgia 31210
(478) 405-4500
A Division Of Navicent Health, Inc.