



EAST GREENWICH

**Application Form For Admission**

The Seasons \_\_\_\_\_

Grandview Gardens \_\_\_\_\_

Date Recv'd \_\_\_\_\_

Five Saint Elizabeth Way East Greenwich RI 02818 Telephone: 401-884-9099 Fax: 401-884-7439

The following is an application for admission to The Seasons East Greenwich. Criteria for admission is the same for all persons without regard to race, gender, national origin, physical or cognitive impairments. Please call with any questions or for assistance with completing this application.

**GENERAL INFORMATION**

Applicant's Name \_\_\_\_\_  
(Salute) (First Name) (Middle Initial) (Last Name)

Address \_\_\_\_\_ Social Security \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Date of Birth \_\_\_\_\_

Telephone \_\_\_\_\_ Age \_\_\_\_\_

Present Residence is: Home \_\_\_\_\_ Apartment \_\_\_\_\_ Other \_\_\_\_\_

Marital Status \_\_\_\_\_ If married, then spouse's name \_\_\_\_\_

**Primary Physician**

Physician's Name: \_\_\_\_\_ Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

**In Case of Emergency Contact**

**First**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tele: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email: \_\_\_\_\_

**Second**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tele: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email: \_\_\_\_\_

**Financial Information**

Medical Insurance: Type: \_\_\_\_\_ Policy#: \_\_\_\_\_  
*(Blue Cross, Oceanstate, John Hancock, etc.)*

Other Insurance Type: \_\_\_\_\_ Policy #: \_\_\_\_\_

Federal Medicare # \_\_\_\_\_ Part A \_\_\_\_\_ Part B \_\_\_\_\_

**Financial Resources**

Total assets including home : \_\_\_\_\_ ( please provide supporting documentation)

Your monthly income: Social Security \_\_\_\_\_ Pension: \_\_\_\_\_ Trusts: \_\_\_\_\_

Other: \_\_\_\_\_

**Financial Responsible Party**

*(Individual who will receive the invoice and ensure payment)*

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Tele: (H) \_\_\_\_\_ (W) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email: \_\_\_\_\_

**List all Health Problems:** \_\_\_\_\_

**List any Behaviors that might require extra supervision such as wandering, elopement risk and sundowning:**

**Mobility:** \_\_\_\_\_ Independent \_\_\_\_\_ Cane \_\_\_\_\_ Walker \_\_\_\_\_ Self propelled Wheelchair

Other-explain: \_\_\_\_\_

**I need Assistance with:**

\_\_\_\_\_ Medication Administration \_\_\_\_\_ Bathing \_\_\_\_\_ Dressing \_\_\_\_\_ Escort Service

\_\_\_\_\_ Housekeeping & Laundry \_\_\_\_\_ Incontinence Mgt. \_\_\_\_\_ Other-explain: \_\_\_\_\_

Applicant's Signature \_\_\_\_\_ Date: \_\_\_\_\_

I fully understand that this is just an application for the Seasons East Greenwich waiting list.  
**Enclosed is a fully refundable deposit check of \$ \_\_\_\_\_ made payable to the Seasons East Greenwich Inc.**