SpringBrook Community Assisted Living
861 Critter Court ~ Onalaska, WI 54650
608.793.5124 Office
608.783.1182 Fax

POTENTIAL RESIDENT INFORMATION FORM

Applicant _____ M/F DOB ____/____/____

Co-Applicant _____ M/F DOB ____/____/____

Address _____ Phone (____) _____ - _____

City/State/Zip Code _____ County _____

Indicate Temporary Address (if applicable) _____

Health Care Power of Attorney (HCPOA) Y / N (Attach copy to application)

Durable Power of Attorney (DPA) – for financial matters Y / N (Attach copy to application)

Applicant Social Security Number_____-_____-_____

Co-Applicant Social Security Number_____-_____-_____

Persons who have agreed to provide any needed support to applicant:

Primary

Name _____ Relationship _____

Address _____ Home Phone _____

City/State/Zip Code _____ Work Phone _____

Secondary

Name _____ Relationship _____

Address _____ Home Phone _____

City/State/Zip Code _____Work Phone_____

Personal Information:

Occupation prior to retirement:_____

Spouse Occupation: _____

Current Marital Status:

Widowed_____ Single _____ Married _____ Years Married _____

Religion _____

Military Status _____

Education _____

Children _____

Interests, Hobbies, Awards, Accomplishments, etc. _____

_____

_____

_____

Referral Source:

SpringBrook Website _____ Facebook Page _____

Newspaper _____ Name _____

Hospital_____Name_____

Church Bulletin _____ Name of Church_____

Current or Former Resident _____ Friend _____ Family _____ Other _____

Financial Information:

If married, the total income and assets of both spouses must be listed. Information will remain confidential.

Sources of Income per Month	**Applicant**	**Spouse**
Social Security	$_____	$_____
Pension (Type) _____	$_____	$_____
Dividends	$_____	$_____
Interest	$_____	$_____
Pension (Specify) _____	$_____	$_____
	Total Income per Month	$_____

Total Assets (applicant and spouse)

Pension or 401K Balance	$_____
Checking Account(s) Balance	$_____
Savings Account(s) Balance	$_____
Certificate of Deposit	$_____
Bonds (Type) _____	$_____
(Type) _____	$_____
Money Market Accounts	$_____
Total Liquid Assets:	**$_____**

Real Estate: Address_____

_____

Market Value $_____ Balance Owed $_____

Other Assets (list and describe) _____

Medical Information:

Please list the names of health care professionals who will be serving you (and your spouse, if applicable):

Primary Physician _____

Address _____

City/State/Zip Code _____ Phone (____) _____ - _____

Dentist _____

Address _____

City/State/Zip Code _____ Phone (____) _____ - _____

Optometrist_____

Address _____

City/State/Zip Code _____ Phone (____) _____ - _____

I certify that the information contained within this application is a true and complete statement of facts.

_____ _____/_____/_____
Signature of Applicant Date

_____ _____/_____/_____
Signature of Co-Applicant (if applicable) Date

_____ _____/_____/_____
Signature of HCPOA Date

_____ _____/_____/_____
Signature of DPA Date