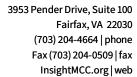




INSIGHT MEMORY CARE CENTER

APPLICATION FORM

Name:	Preferred Name/Nickname:
Address:	
Email:	Telephone:
Desired Start Date:	Preferred Days:
Social Security Number:	Marital Status:
Medicare Number:	Effective Date:
Medicaid Number:	Effective Date:
Other Insurance:	Effective Date:
Birth Date: Age:	Place of Birth:
Hospital Preference:	Hospital Address:
HOW DID YOU HEAR ABOUT INSIGHT? □ Family/Friend □ Doctor □ Aging Life Care Manager Other, or details on above:	□ Church/Clergy □ Online □ Ad
RESPONSIBLE PARTY/GUARDIAN	EMERGENCY CONTACT #2
Name:	Name:
Address:	Address:
Telephone:	Telephone:
mail	





EMERGENCY CONTACT #3		LOCAL PRIMARY CARE PHYSICIAN	
Name:		Name:	
Addres	s:	Address:	
Γelepho	ne:	Telephone:	
Email:		☐ \$100 Application Fee Included	
PERSO	NAL PHYSICIAN	SOCIAL SERVICES PROVIDER	
Name:		Name:	
Addres	s:	Address:	
Telephone:		Telephone:	
Email: _		Email:	
On a so	cale of 1-5, please rate your loved one's current engagem	ent in the following:	
1.	Physical Activities		
	(e.g. walking, chair or standing exercise, ball toss, etc.)		
2.	Cognitive Activities		
	(e.g. reading/writing, crosswords, sudokus, puzzles, etc.)		
3.	Social Activities		
	(e.g. conversing with friends/family, outings, etc.)		
4.	Creative Activities		
	(e.g. artwork, woodworking, etc.)		
5.	Musical Activities		
	(e.g. singing, listening to music, attending concerts, etc.)		
6.	Outdoor/Nature Activities		
	(e.g. outdoor walks, gardening, etc.)		