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

*Note: The financial information listed on this form is required in order to qualify for admission to SpringBrook, and to execute a Service Agreement or Admission Agreement upon the start of residency. SpringBrook Policy, Service Agreements, and Admission Agreements state that residents must fulfill their obligation of 24 months of private payment prior to converting to public funding. Failure to do so may result in SpringBrook issuing a 30 day termination notice.