



861 Critter Court
Onalaska, WI 54650
Phone: 608.783.2292
Fax: 608.783.1182

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 _____ - _____ - _____

Emergency Contacts:

Primary

Name _____ Relationship _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

Secondary

Name _____ Relationship _____

Address _____ City/State/Zip _____

Home Phone _____ Cell Phone _____

Work Phone _____ Email _____

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. We require documentation for each income and asset item listed. You may cross out account numbers, etc, but please leave your name on the document. 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 Health Care Power of Attorney (HCPOA)

_____/_____/_____
Date

Signature of Financial Power of Attorney (FPOA)

_____/_____/_____
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.