LEGACY
ASSISTED LIVING

Phone: 208-840-2011
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RESIDENT INQUIRY & PRELIMINARY APPLICATION

Purpose: Thank you for your interest in Legacy Assisted Living. This helps us learn more about the prospective resident and determine whether our community may be a good fit. Completion of this form does not guarantee admission.

RESIDENT INFORMATION

Resident Full Name: _____

Date of Birth: _____

Gender: ☐ Male ☐ Female

Current Address:

_____

_____

Current Living Situation:
☐ Private Home
☐ Assisted Living
☐ Memory Care
☐ Skilled Nursing Facility
☐ Hospital
☐ Rehabilitation Center
☐ Other: _____

Desired Move-In Date:
☐ Immediately
☐ Within 30 Days
☐ Within 60 Days
☐ Within 90 Days
☐ Just Gathering Information

PRIMARY CONTACT / RESPONSIBLE PARTY

Name: _____

Relationship to Resident: _____

Phone: _____

Email: _____

Address (if different from resident): _____

Preferred Contact Method: ☐ Phone ☐ Email ☐ Text Message

LEGAL DECISION MAKING
Does the resident have:

Durable Power of Attorney? ☐ Yes ☐ No

Healthcare Power of Attorney? ☐ Yes ☐ No

Legal Guardian? ☐ Yes ☐ No

If yes, please provide contact information:

GENERAL HEALTH INFORMATION
Please check any conditions that currently apply:
☐ Dementia
☐ Alzheimer's Disease
☐ Mild Memory Loss
☐ Parkinson's Disease
☐ Stroke
☐ Diabetes
☐ Heart Disease
☐ COPD / Respiratory Disease
☐ Cancer
☐ Anxiety
☐ Depression
☐ None of the Above
Other Medical Conditions:

MOBILITY & CARE NEEDS
Resident currently walks:
☐ Independently
☐ With a Cane
☐ With a Walker
☐ With a Rollator
☐ Uses a Wheelchair
☐ Requires Assistance
Resident requires help with:
☐ Bathing
☐ Dressing
☐ Grooming

☐ Toileting
☐ Medication Management
☐ Transfers
☐ Meal Preparation
☐ Housekeeping
☐ Laundry
☐ No Assistance Needed

MEMORY & COGNITIVE STATUS
Does the resident experience any of the following?
☐ Forgetfulness
☐ Repeating Questions
☐ Confusion
☐ Wandering
☐ Exit Seeking
☐ Difficulty Managing Medications
☐ Difficulty Making Decisions
☐ None

MEDICATION ASSISTANCE
Approximately how many medications does the resident take daily?
☐ 0–3
☐ 4–7
☐ 8–12
☐ More than 12
Does the resident require medication assistance? ☐ Yes ☐ No ☐ Unsure

ADDITIONAL SERVICES
Does the resident currently receive any of the following?
☐ Home Health
☐ Physical Therapy
☐ Occupational Therapy
☐ Speech Therapy
☐ Hospice
☐ Private Caregiver
☐ None

FINANCIAL INFORMATION
Expected payment source:
☐ Private Pay
☐ Long-Term Care Insurance
☐ Veterans Benefits
☐ Medicaid Waiver
☐ Other: _____

APARTMENT PREFERENCES

Interested In:

☐ Studio Apartment

☐ One-Bedroom Apartment

☐ Larger Apartment

☐ Unsure

Will a spouse or companion be moving in? ☐ Yes ☐ No

TELL US ABOUT THE RESIDENT

Please tell us anything else that would help us understand the resident's needs, interests, personality, hobbies, or care requirements.

TOUR REQUEST

Would you like to schedule a tour? ☐ Yes ☐ No ☐ Already Completed

Preferred Tour Date/Time:

NEXT STEPS

Thank you for your interest in Legacy Assisted Living.

Once we receive your inquiry, a member of our Admissions Team will contact you within **1–2 business days** to discuss the resident's needs, answer questions, and determine whether Legacy Assisted Living may be a good fit.

If appropriate, the next steps may include:

- Scheduling a tour
- Completing a clinical care assessment
- Reviewing apartment availability
- Discussing services and pricing
- Coordinating a move-in plan

Submitting this inquiry does not guarantee admission. Admission decisions are based on apartment availability and our ability to safely meet the resident's care needs.

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