

RESIDENTIAL FACILITIES – RESIDENT PROFILE

Name of Applicant: _____

1. Complete for each resident – no names. Please submit for each location.

| Resident | Age | Description of ability to ambulate (can transfer themselves, bear weight, wheelchair bound, uses walker non-ambulatory, etc) | Primary Diagnosis - i.e. age-related infirmity, developmental disability, mental health (if mental health describes diagnosis) |
|----------|-----|---|--|
| #1 | | | |
| #2 | | | |
| #3 | | | |
| #4 | | | |
| #5 | | | |
| #6 | | | |

2. Other Services

Do you have any residents not described above? _____

Do any residents have a history of violent behavior? _____

Do you accept tube feeding or ventilator care residents? _____

3. Number of patients/residents suffering from Alzheimer's Disease or Dementia _____

Applicant Signature

Date