
HEALTH INFORMATION

Primary Physician _____ Telephone _____
Present Address _____ Email _____
City _____ State _____ Zip _____

Statement of Health Status

- A. Yes No Do you use a walker or cane?
- Yes No Do you need medication management?
- Yes No Does vision impairment impact your life?
- Yes No Do you currently have care at home?
- Yes No Do you have any special dietary needs/allergies?
- Yes No Have you been diagnosed with a memory impairment?
- Yes No Do you maintain yearly or more frequent doctor visits?

Explanation of any "yes" responses:

Question No. Explanation

Question No.	Explanation

Name of Medication	Dosage	Frequency	Reason for Taking Medication

To complete your application for the Wait List, please submit a 100% refundable check for \$500, or applied to your one-time Community Fee, per person made to the order of Rhoda Goldman Plaza.
Our Nurse Manager will review the application and upon approval, your name will be placed on a Waiting List by date of approval, and a letter of confirmation will be sent to you. A more comprehensive application and its approval will be required by Rhoda Goldman Plaza management, which includes a financial report and health-care supporting documentation, before residency is accepted.

I understand that all information supplied will become part of the agreement I will make with Rhoda Goldman Plaza at the time I become a resident. I understand that any misrepresentation, concealment, or omission may cause the agreement to be voided, and that all the information in this application will be maintained in confidence by Rhoda Goldman Plaza.

Signature of Applicant or Responsible Party _____ Date _____

Name of Applicant or Responsible Party _____