

**Kendal-Crosslands Communities
Resident Information Form**

Dear Resident: To complete our records, the following information is needed. Whenever any change occurs, please notify the Administrative Office or Resident Care Department as this information should always be kept current. Any additional information you feel would be helpful in the event of an emergency should be attached. (revision February 2020)

Mr/Mrs/Ms/Miss/Dr				
First Name: _____	Middle Initial: _____	Last Name: _____		
Nickname: _____	Date of Birth: _____	Birth Place: _____		
Apt. # _____	Kendal	Crosslands	Cartmel	Coniston
Address: _____				
Phone Number: _____		Cell Phone: _____	Email address: _____	

Information for Hospital or Skilled Nursing Admissions:

Social Security #: _____ Medicare #: _____

Secondary Insurance Carrier: _____ Account #: _____

Religious Denom: _____ Church: _____

Race: _____ Previous Occupation: _____ Education (Highest) : _____

Marital Status: _____ Spouse's Name: _____

Accident or Emergency/Notification:

If applicable, please list your co-occupant of your KCC cottage or apartment as the first to be notified.

1)Name: _____ Relationship _____

Address: _____

E-mail address: _____

Tel Home: _____ Tel Wk: _____ Tel Cell: _____

***Please select the phone number above which should be used first in the event of an emergency:

2)Name: _____ Relationship _____

Address: _____

E-mail address: _____

Tel Home: _____ Tel Wk: _____ Tel Cell: _____

***Please select the phone number above which should be used first in the event of an emergency:

Designated Friend (Emergency/Notification for Kendal Community Contact):

Please designate a fellow Kendal~Crosslands resident we should inform in the event you have a medical emergency, for purposes of community information/notification:

Name: _____ Relationship _____

Address: _____

E-mail address: _____

Tel Home: _____ Tel Wk: _____ Tel Cell: _____

Yes or No: I give consent for my Designated Friend to receive Protected Health Information. However, this individual will have no power to participate in decisions about my healthcare.

Other Persons Authorized for Sharing/Release of Protected Health Information:

In the event of your incapacity or sudden illness, Health Services staff may also release protected health information to the relative, friend, or fellow resident named here. This individual will have no power to participate in decisions about my healthcare.

Name: _____ Relationship _____

Address: _____

E-mail address: _____

Tel Home: _____ Tel Wk: _____ Tel Cell: _____

Durable Power of Attorney (DPOA) for Healthcare:

A DPOA is an individual whom you have specifically designated by completing a DPOA form. A person acting as your agent under a DPOA for Healthcare has the authority to make health care decisions on your behalf in the event that you become incapacitated. DPOA forms are available from Administration and/or the Resident Care Department.

Name: _____ Relationship _____

Address: _____

E-mail address: _____

Tel Home: _____ Tel Wk: _____ Tel Cell: _____

Successor Durable Power of Attorney (DPOA) for Healthcare:

Name: _____ Relationship _____

Address: _____

E-mail address: _____

Tel Home: _____ Tel Wk: _____ Tel Cell: _____

Advance Directive (Living Will):

An advance directive document, sometimes referred to as a living will, is a document that provides health care providers with information about your wishes regarding treatment should you become incapacitated. Resident are strongly encouraged to complete an advance directive in consultation with their primary care physician and make sure the document is on file with us. A POLST (Physician’s Orders for Life Saving Treatment) form provides similar instructions for emergency medical technicians responding to 911.

Power of Attorney (POA) for financial affairs:

The person you appoint as your agent under a POA for financial affairs enables that individual to act on your behalf with regard to legal and financial matters. You will normally obtain these documents from your attorney.

Name: _____ Relationship _____

Address: _____

E-mail address: _____

Tel Home: _____ Tel Wk: _____ Tel Cell: _____

Executor:

Please supply us with the names of all persons who you have stipulated in your last will and testament as your Executor(s). The executor of your estate, or their formal designee, will be the only person who will have the legal authority to enter your premises after your death, or to whom we can release your personal property. My Executor(s) is(are):

1) Name: _____ Relationship _____

Address: _____

E-mail address: _____

Tel Home: _____ Tel Wk: _____ Tel Cell: _____

2) Name: _____ Relationship _____

Address: _____

E-mail address: _____

Tel Home: _____ Tel Wk: _____ Tel Cell: _____

Funeral Home/Director, Cremation Society or Humanity Gifts: Organ Donor?

It is important that you contact a local funeral director so that he/she can be advised about funeral preplanning arrangements. If you intend to donate your organs, or have made arrangements with the Humanity Gifts Registry, please supply copies of the appropriate documents with this form.

Name: _____ Tel: _____

Address: _____

Casket Burial: Cremation: Organ Donor: Yes No
If organ donor, provide documentation

All the information I have submitted above is accurate as of the date of this form, and I acknowledge my responsibility to update the form as I make changes to the information in the future.

Resident Signature: _____ Date: _____