

Residency Application Form

|                      |   |                     |                             |
|----------------------|---|---------------------|-----------------------------|
| <b>ANNEXURE: 1</b>   | <b>Residency Application Form</b>                           |                     |                             |
| <b>CHAPTER: 4</b>    | <b>Care Home Rules, Policies, Operations and Management</b> |                     |                             |
| <b>MONTH CREATED</b> | <b>December 2024</b>  | <b>NEXT REVIEW</b>  | <b>December 2026</b>        |
| <b>CHAPTER CODE</b>  | <b>CHRP</b>   | <b>VERSION</b>      | <b>1</b>                    |
| <b>PREPARED BY</b>   | <b>Pankaj Mehrotra</b>                                      | <b>UNDER REVIEW</b> | <b>Dr. Dipankar Debnath</b> |

|                            |                    |   |                |
|----------------------------|--------------------|---|----------------|
| Care Home Name             |                    |   | Resident Photo |
| Address                    |                    |   |                |
| Contact Nos                |                    |   |                |
| Email ID                   |                    |   |                |
| License / Registration No. |                    |   |                |
| Care Type                  | Assisted Living    | Independent Living                          | Remarks        |
|                            | Dementia Care      | Transitional Care / Rehabilitation          |                |
|                            | Nursing Care       | Respite Care/ Short Term Care               |                |
|                            | Palliative/Hospice | Mental Care                                 |                |
| Gender Type                | Men                | Women                                       |                |
|                            | Men & Women        | Special Needs (Blind / Physical Impairment) |                |
| Charging Type              | Paid               | Free  |                |
|                            | Paid & Free        | Govt Funded                                 |                |
| Entity Type                | Govt               | Private                                     |                |
|                            | NGO                | Public Private Partnership                  |                |

**A) Personal Information**

1) Name (Capital Letters): Mr/Ms: \_\_\_\_\_

2) Date of Birth: \_\_\_\_\_ Gender: Male \_\_\_ Female: \_\_\_ Third Gender: \_\_\_\_\_

3) Address: (Capital Letters) \_\_\_\_\_

\_\_\_\_\_ Pin Code: \_\_\_\_\_

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4) Contact Number: \_\_\_\_\_

5) Email ID: (Capital Letters) \_\_\_\_\_

6) Educational Qualifications: \_\_\_\_\_

7) Professional Background: \_\_\_\_\_

8) Marital Status: Single: \_\_\_\_\_ Married: \_\_\_\_\_

9) Spouse Name: \_\_\_\_\_

10) Do you have Medical Insurance: Yes: \_\_\_ No: \_\_\_ Life Insurance: Yes: \_\_\_ No: \_\_\_

11) Medical Insurance:

i) Policy No: \_\_\_\_\_ Valid From & To: \_\_\_\_\_

ii) Name of Medical Insurer: \_\_\_\_\_

iii) Other Medical Providers: CGHS, ECHS, State Medical, PSU Medical

12) Life Insurance:

i) Policy No: \_\_\_\_\_ Valid From & To: \_\_\_\_\_

ii) Name of Life Insurer: \_\_\_\_\_

13) AADHAR Card No: \_\_\_\_\_ PAN Card No: \_\_\_\_\_

**B) Fees & Payments:**

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1) Who will pay the Home Charges & Fees: Self: \_\_, Family: \_\_, Friends: \_\_, Govt: \_\_\_\_

If funded by Family/Friends: Name \_\_\_\_\_

Address: \_\_\_\_\_

Contact Nos: \_\_\_\_\_ Email: \_\_\_\_\_

2) Emergency / Guardian Contact Names & Details:

i) Name (Capital Letters): Mr/Ms: \_\_\_\_\_

Relationship with Applicant / Resident: Son: \_\_\_\_\_ Daughter: \_\_\_\_\_

Relative/Friend: \_\_\_\_\_ Others: \_\_\_\_\_

Postal Address: (Capital Letters) \_\_\_\_\_

\_\_\_\_\_ Pin Code: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email ID: (Capital Letters) \_\_\_\_\_

ii) Name (Capital Letters): Mr/Ms: \_\_\_\_\_

Relationship with Applicant / Resident: Son: \_\_\_\_\_ Daughter: \_\_\_\_\_

Relative/Friend: \_\_\_\_\_ Others: \_\_\_\_\_

Postal Address: (Capital Letters) \_\_\_\_\_

\_\_\_\_\_ Pin Code: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email ID: (Capital Letters) \_\_\_\_\_

3) Visitors: Who are the people likely to call or visit you:

\_\_\_\_\_

4) Who are the people you don't want them to call or visit you:

\_\_\_\_\_

**C) Advance Directives:**

1) If there is a health emergency or accident which needs you to be taken to a Hospital would you like the Home staff to wait for your relatives to take you to the hospital?

Yes: \_\_\_\_\_ No: \_\_\_\_\_

2) In-case of Medical Emergency, do you want to take CPR: Yes: \_\_\_\_\_ No: \_\_\_\_\_  
DNR: Yes \_\_\_\_\_ No: \_\_\_\_\_

**D) Demise & Last Rites:**

1) Who are the people you want them to do your last rites?

Son: \_\_\_\_\_ Daughter: \_\_\_\_\_ Relative/Friend: \_\_\_\_\_ Care Home: \_\_\_\_\_

2) Religious Beliefs and Customs to be followed:

\_\_\_\_\_

3) Who are your legal heirs/next of kin and their addresses?

Name (Capital Letters): Mr/Ms: \_\_\_\_\_

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Relationship with Applicant / Resident: Son: \_\_\_\_\_ Daughter: \_\_\_\_\_

Relative/Friend: \_\_\_\_\_ Others: \_\_\_\_\_

Postal Address: (Capital Letters) \_\_\_\_\_

\_\_\_\_\_ Pin Code: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email ID: (Capital Letters) \_\_\_\_\_

4) Whom would you like your personal belongings and valuables if any to be handed over after your death? Address, ID, Signature and Picture for Identification.

i) Name (Capital Letters): Mr/Ms: \_\_\_\_\_

Relationship with Applicant / Resident: Son: \_\_\_\_\_ Daughter: \_\_\_\_\_

Relative/Friend: \_\_\_\_\_ Others: \_\_\_\_\_

Contact Number: \_\_\_\_\_

Email ID: (Capital Letters) \_\_\_\_\_

**E) Health and Medical Information:**

1) Blood Group: \_\_\_\_\_

2) Any Serious illnesses: Yes: \_\_\_ No: \_\_\_, If Yes, give details: \_\_\_\_\_

3) Any regular/essential Medications: Blood Pressure: Yes: \_\_\_\_\_ No: \_\_\_\_\_ Diabetes: Yes \_\_\_ No: Cholesterol: Yes: \_\_\_ No: \_\_\_\_\_ Others: \_\_\_\_\_

4) Past Medical History: Surgeries: Yes: \_\_\_\_\_ No: \_\_\_\_\_, Illnesses: Yes: \_\_\_\_\_ No: \_\_\_\_\_

**F) Reason(s) for joining the Care Home:**

|   |                                |                                 |
|---|--------------------------------|---------------------------------|
| Health & Medical Requirement            | Physical Security              | Social Interaction & Well-being |
| Living Alone                            | Homeless / Poverty             | Dementia                        |
| Transitional Care / Rehabilitation Care | Respite Care / Short Term Care | Disaster Affected               |
| Court Directions                        | Family Disputes                | Mental Health                   |

**G) Legal Information:**

1) Existing Court Cases: Yes: \_\_\_ No: \_\_\_, Convicted of a Crime: Yes: \_\_\_\_\_ No: \_\_\_\_\_

2) Do you have a Will: Registered Will: Yes: \_\_\_ No: \_\_\_ Non-registered Will: Yes: \_\_\_ No: \_\_\_

3) Have you Lived in or applied for admission to any other similar Care Home earlier: Yes: \_\_\_\_\_ No: \_\_\_\_\_, If yes then reason for leaving:

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**H) Hobbies and Interests:** \_\_\_\_\_

**I) Allotted Room Details:**

1) Room Number: \_\_\_\_\_

2) Single / Twin Sharing / Dormitory: \_\_\_\_\_

3) Twin Sharing Resident: Couples: Yes: \_\_\_ No: \_\_\_, Other Resident: Yes \_\_\_\_\_ No: \_\_\_

4) Room Type: Studio: Yes: \_\_\_ No: \_\_\_, Suite: Yes: \_\_\_ No: \_\_\_, Dormitory: Yes: \_\_\_\_\_ No: \_\_\_

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I/We, \_\_\_\_\_, have read/heard and understood the contents of the above form in my vernacular language and certify that the information given by me is correct.

I, \_\_\_\_\_ S/o/D/o. \_\_\_\_\_, hereby certify that I have read and understood the rules and regulations of the Care Home and I undertake to abide by them. I understand that I can be expelled for repeated or willful non-compliance of the Care Home Rules and Policies.

Dated: \_\_\_\_\_ Signature: Self: \_\_\_\_\_

Guardian / Family Member: \_\_\_\_\_