NEW RESIDENT ACCOUNT SETUP
GPW-GPE-LC-SO

Resident Last Name: ______________________ First: ________________ M.I._______

Responsible Party: __________________________ Relationship: ___________________

Billing
Address: ____

Address Line 2:____

City: _______________________ State: ___________ Zip: ________________

Primary Phone Number: (______) ____________________________

Alt. Phone: (______) ____________________________

Secondary Contact: ________________________________ Relationship: ____________

Billing
Address: ____

Address Line 2: ____

City: ___________________ State: ________ Zip: ________________________

Primary Phone Number: (______) ________________________

Alt. Phone: (______) ________________________

Room Type: ( ) Private ( ) Semi-Private ( ) Suite

Building: _______ Room Number: _________ ETA: ____________

Level of Care

1- Independent Living
2- Medication Management
3- Personal Care Management
4- Incontinence Management
5- Alzheimer's/Dementia
6- Alzheimer's / Dementia with Incontinence
7- Hospice Care
8- Wheelchair Management
9- Companion Care
10- Respite Care

Processing Fee: $______________________

Monthly Room Rate: $______________________

D Code_____ AMT. ______________________

Deposit $______________________ Date Paid: _________________

Balance Due $______________________