

# CLARK RETIREMENT COMMUNITY



## Application for Respite Stay

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**Desired Location for Respite Stay**

Clark On Franklin

Clark On Keller Lake

**Dates for Respite Stay**

From

To

### PERSONAL INFORMATION

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Name

Phone (       )

Address

City / State / Zip

Date of Birth

Social Security Number

Marital Status    Married    Single    Divorced    Widowed

Name of Spouse, if applicable

Living

Deceased (Date)

*Person to be notified about Respite Stay at Clark if other than applicant.*

Name

Home Phone (       )

Address

Cell Phone (       )

City / State / Zip

Work Phone (       )

E-mail Address

### Church Affiliation

Denomination

Name of Pastor

Address

Phone (       )

City / State / Zip

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### MEDICAL INFORMATION

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**Physician Name**

Address

City / State / Zip

Phone (            )

Fax (            )

Hospital Preference

Funeral Home Preference

Address

Phone (            )

City/State/Zip

### INSURANCE INFORMATION

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**Primary Insurance/Medicare Number**

**Other Health Insurance / Type Of Insurance**

Name of Insurance Company

Insurance Policy Number

Billing Address

Phone (            )

**Long Term Care Insurance**

Name of Insurance Company

Insurance Policy Number

Billing Address

Phone (            )

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### EMERGENCY CONTACTS

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Clark recommends that residents designate a durable power of attorney (DPOA) and a health care power of attorney which is called a Patient Advocate in Michigan.

Please list each person, their level of responsibility (DPOA and/or Patient Advocate) and the order you wish them contacted in the event of an emergency. You give Clark permission to share health information with these individuals.

Name	Responsibility
Address	Home Phone (       )
City / State / Zip	Cell Phone (       )
E-mail Address	Work Phone (       )

Name	Responsibility
Address	Home Phone (       )
City / State / Zip	Cell Phone (       )
E-mail Address	Work Phone (       )

Name	Responsibility
Address	Home Phone (       )
City / State / Zip	Cell Phone (       )
E-mail Address	Work Phone (       )

Statements from Clark should be sent to \_\_\_\_\_

# CLARK RETIREMENT COMMUNITY



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How did you hear about Clark Retirement Community?

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Why did you select Clark Retirement Community?

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Do you know someone who lives here?  No  Yes If yes, who?

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Why is Respite required at this time?  Vacation  Medical  Emergency  Caregiver Relief  Other  
(Please Explain)

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I hereby make my application to Clark Retirement Community for a Respite Stay and affirm that my answers on this application are true and fairly represent the facts. My signature below confirms my ability to privately pay for the designated Respite Stay.

**Signature of Applicant**

**Date**

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**Other Responsible Party**

**Date**

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**Relationship to Applicant**

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The following documents are needed at the time of contract signing:

Copies of Insurance cards

Chest x-ray written report (Must be taken within 90 days of the Respite Stay)

Medical Report

- History & Physical dated within 90 days of the Respite Stay
- Medication list

DPOA & Health Care Advocate if applicable

Completed Clark Life Story form

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Clark Retirement Community

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Franklin Campus  
1551 Franklin Street, SE  
Grand Rapids, Michigan 49506

|  
Keller Lake Campus  
2499 Forest Hill, SE  
Grand Rapids, Michigan 49546

|  
616-452-1568 telephone  
800-770-1117 toll free  
616-452-0428 facsimile  
www.clarkretirement.org