



Oak Side Haven Senior Living

Resident Application & Admission Packet

Compassionate Care in a Home-Like Setting

Schererville Location: 725 Oakside Dr., Schererville, IN 46375

Portage Location: 2899 Christy Street, Portage, IN 46368

219-350-6173 | info@oaksid havenseniorliving.com | www.oaksid havenseniorliving.com

APPLICATION NOTICE

Completion of this application does not guarantee acceptance or admission. Oak Side Haven Senior Living reviews each applicant to determine whether our residential setting can safely and appropriately meet the resident's needs.

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Please complete all applicable sections and attach copies of requested documents before submission.

1. WELCOME LETTER

Dear Resident and Family,

Welcome to Oak Side Haven Senior Living. At Oak Side Haven, we believe every individual deserves to age with dignity, comfort, and respect in a warm, home-like environment.

Our mission is to provide compassionate, personalized care while supporting independence, safety, comfort, and meaningful daily living. Our homes are designed to feel peaceful, structured, and welcoming - not institutional.

Oak Side Haven offers all-inclusive residential senior living services, including home-cooked meals and snacks, housekeeping, laundry, medication reminders, transportation assistance for local appointments when arranged, and meaningful activities.

We understand that choosing a new home is an important decision. This application helps us learn about the prospective resident's needs, preferences, routines, and supports so we can determine whether Oak Side Haven is the right fit.

Sincerely,

Kardetra Redmond

Kardetra Redmond
 Owner & Administrator
 Oak Side Haven Senior Living

2. RESIDENT INFORMATION

Desired Location	<input type="checkbox"/> Schererville <input type="checkbox"/> Portage
Legal Name	
Preferred Name	
Date of Birth / Age	
Gender	
Social Security Number	
Marital Status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced
Veteran Status	<input type="checkbox"/> Yes <input type="checkbox"/> No
Primary Language	
Religious Preference (Optional)	
Current Address	
City / State / ZIP	
Primary Phone	
Email	
Preferred Hospital	

3. EMERGENCY CONTACTS

Primary Contact Name	
Relationship	
Phone	
Email	
Address	
Secondary Contact Name	
Relationship	
Phone	
Email	
Address	

4. RESPONSIBLE PARTY & BILLING

Responsible Party Name	
Relationship to Resident	
Phone	
Email	
Billing Address	
Financial Responsibility Accepted	<input type="checkbox"/> Yes <input type="checkbox"/> No
Preferred Billing Method	<input type="checkbox"/> Email <input type="checkbox"/> Mail <input type="checkbox"/> Other: _____

A separate financial agreement may be required before move-in.

5. LEGAL AUTHORITY & ADVANCE DIRECTIVES

Medical Power of Attorney	
Phone / Email	
Financial Power of Attorney	
Phone / Email	
Guardian	
Representative Payee	
Living Will	<input type="checkbox"/> Yes <input type="checkbox"/> No
Advance Directive	<input type="checkbox"/> Yes <input type="checkbox"/> No
DNR / Code Status	<input type="checkbox"/> DNR <input type="checkbox"/> Full Code <input type="checkbox"/> Unknown
Copies Attached	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. PHYSICIAN, PHARMACY & INSURANCE

Primary Physician	
Phone	
Specialist(s)	
Preferred Pharmacy	
Pharmacy Phone	
Insurance Provider	
Policy / Member Number	
Medicare Number	
Medicaid Number	
Home Health Agency	
Hospice Provider	

7. MEDICAL HISTORY ASSESSMENT

Primary Diagnosis	
Secondary Diagnoses	
Allergies	
Recent Hospitalizations / ER Visits	
Past Surgeries	
Vision Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Uses Oxygen	<input type="checkbox"/> Yes <input type="checkbox"/> No
CPAP / BiPAP	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall History in Past 12 Months	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fall Details	
Continance Status	<input type="checkbox"/> Independent <input type="checkbox"/> Occasional Assistance <input type="checkbox"/> Incontinent

MOBILITY DEVICE

<input type="checkbox"/> None	<input type="checkbox"/> Cane	<input type="checkbox"/> Walker
<input type="checkbox"/> Wheelchair	<input type="checkbox"/> Scooter	<input type="checkbox"/> Other: _____

8. ACTIVITIES OF DAILY LIVING (ADL) ASSESSMENT

Activity	Independent	Cueing	Assistance	Dependent
Bathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dressing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Toileting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grooming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Transfers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ambulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Medication Reminders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laundry / Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal Set-Up	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

9. MEDICATION INFORMATION

Medication	Dose	Frequency	Prescriber	Purpose / Notes
Resident Self-Administers Medications	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Medication List Attached	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Pharmacy Packaging Required	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> To Be Determined			

10. COGNITIVE & BEHAVIORAL ASSESSMENT

<input type="checkbox"/> Memory impairment	<input type="checkbox"/> Dementia diagnosis	<input type="checkbox"/> Wandering/elopement risk
<input type="checkbox"/> Sundowning	<input type="checkbox"/> Depression	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Sleep disturbances	<input type="checkbox"/> Verbal aggression	<input type="checkbox"/> Physical aggression
<input type="checkbox"/> Refuses care at times	<input type="checkbox"/> Confusion at night	<input type="checkbox"/> Other: _____

11. DIETARY PREFERENCES

DIET TYPE

<input type="checkbox"/> Regular	<input type="checkbox"/> Diabetic	<input type="checkbox"/> Low Sodium
<input type="checkbox"/> Mechanical Soft	<input type="checkbox"/> Pureed	<input type="checkbox"/> Other: _____
Food Allergies		
Favorite Foods		
Foods to Avoid		
Beverage Preferences		
Religious / Cultural Dietary Needs		

12. ROOM PREFERENCES

Preferred Location	<input type="checkbox"/> Schererville <input type="checkbox"/> Portage
Preferred Room Type	<input type="checkbox"/> Private Room
Furnishing Preference	<input type="checkbox"/> Furnished <input type="checkbox"/> Resident will bring furniture
Desired Move-In Date	
Special Requests	

13. FINANCIAL INFORMATION

PAYMENT SOURCE

<input type="checkbox"/> Private Pay	<input type="checkbox"/> Long-Term Care Insurance
<input type="checkbox"/> VA Benefits	<input type="checkbox"/> Other: _____
Monthly Payment Contact	
Billing Email	
Billing Phone	
Notes	

Oak Side Haven Senior Living is a private-pay residential senior living community. Additional documentation may be requested prior to approval.

14. CONSENTS & AUTHORIZATIONS

Please initial each statement below.

Initials	Acknowledgment
_____	I authorize Oak Side Haven Senior Living to request and review relevant medical information needed to evaluate admission and support resident care.
_____	I consent to medication reminders and medication-related assistance within the scope of Oak Side Haven's residential services.
_____	I authorize Oak Side Haven Senior Living to seek emergency medical treatment if needed and to contact emergency services, physicians, hospitals, responsible parties, or legal representatives as appropriate.
_____	I understand Oak Side Haven Senior Living is a residential senior living home and is not a skilled nursing facility, hospital, or locked memory care facility.
_____	I authorize transportation for scheduled appointments, outings, errands, or other approved activities when arranged and available.
_____	I consent to photographs being used for internal identification, care coordination, emergency identification, and optional family/community updates unless otherwise declined in writing.
_____	I acknowledge that house rules, community expectations, financial agreements, and additional policies may be provided separately and must be followed after admission.

15. RESIDENT RIGHTS & RESPONSIBILITIES

Residents have the right to:

- Be treated with dignity, compassion, and respect.
- Receive services in a safe, clean, and comfortable home-like setting.
- Privacy and confidentiality to the greatest extent possible.
- Participate in decisions affecting daily routines, preferences, and care supports.
- Voice concerns without fear of retaliation.

Residents and families are expected to:

- Treat staff, residents, and visitors with respect.
- Provide accurate information about medical, behavioral, legal, and financial needs.
- Communicate concerns or changes promptly.
- Follow community rules, safety expectations, and signed agreements.

16. MOVE-IN CHECKLIST

REQUIRED / RECOMMENDED BEFORE MOVE-IN

<input type="checkbox"/> Completed application	<input type="checkbox"/> Photo ID
<input type="checkbox"/> Insurance cards	<input type="checkbox"/> Medication list
<input type="checkbox"/> Physician orders, if applicable	<input type="checkbox"/> Legal documents: POA, guardianship, advance directives, DNR
<input type="checkbox"/> Financial agreement completed	<input type="checkbox"/> Emergency contacts confirmed
<input type="checkbox"/> Personal belongings labeled	<input type="checkbox"/> Room furnishings confirmed
<input type="checkbox"/> Preferred pharmacy confirmed	<input type="checkbox"/> Move-in date and time scheduled

17. FINAL SIGNATURE PAGE

By signing below, I certify that the information provided in this application is accurate to the best of my knowledge. I understand that Oak Side Haven Senior Living will review this application to determine whether the resident's needs can be safely and appropriately met in a residential senior living setting.

Resident Name	
Resident Signature	
Date	
Responsible Party / POA Name	
Responsible Party / POA Signature	
Date	
Oak Side Haven Representative	
Signature	
Date	
Witness	