EBENEZER
Loren on Park

2625 Park Ave S., Minneapolis, MN 55407
612-871-4574

APPLICATION FOR RESIDENCY

Please provide all the requested information, sign and initial as noted, and return to Loren on Park.

Apartment Preference:

Assisted Living: ☐ Studio ☐ One Bedroom ☐ Large One Bedroom ☐ Two Bedroom

Date I wish to move in, if accepted: _____ Apartment style preferred _____

Loren on Park is a smoke free Facility and prohibits smoking in any and all areas of the building and grounds. Applicant is a: ☐ Smoker ☐ Non-smoker

1st APPLICANT INFORMATION

Applicant Full Name - Last, First, Middle	Date of Birth	Gender	Marital Status
Present Address	Phone #	Social Security Number	
City	State	Zip Code	
Email:	Veteran or spouse of a Veteran? Yes ____ No ___		
Pet 1: Type: Name:	Branch / years of service _____ (-)		
Pet 2: Type: Name:	Person completing this form (If other than applicant)		
Senior Linkage Number: SL	*To obtain a senior linkage number, call 1-800-333-2433*		

2nd APPLICANT INFORMATION (If Applicable)

2nd Applicant Full Name - Last, First, Middle	Date of Birth	Gender	Marital Status
Present Address	Phone #	Social Security Number	
City	State	Zip Code	
Email:	Veteran or spouse of a Veteran? Yes ____ No ___		
Senior Linkage Number: SL	Branch / years of service _____ (-)		

EMERGENCY CONTACT INFORMATION

First Contact

Name	Relationship	
Address	City/State	Zip Code
Telephone Number ☐ Home ☐ Cell ☐ Work	Email:	

Second Contact

Name	Relationship	
Address	City/State	Zip Code
Telephone Number ☐ Home ☐ Cell ☐ Work	Email:	

By initialing each line below, I authorize Loren on Park to contact the above-named emergency contact person(s) for the following purposes:

_____ To notify such person(s) in the case of an emergency.

_____ To discuss with such person(s) issues regarding my health, finances, and general well-being.

**I understand that these authorizations will continue through my residency at Loren on Park if I become such a resident, unless I void such authorizations in writing.

FINANCIAL INFORMATION

INCOME INFORMATION: List the total of all sources of fixed income e.g., social security, retirement funds, pension, disability, alimony, annuities, SSI, public assistance (attach additional page if needed)

SOURCE (from whom)	AMOUNT	How often is income received?
	$	
	$	
	$	
	$	
	$	
	$	

ASSETS: List the total of all assets, value, and interest on checking /savings accounts, CDs, annuities, money market funds, savings bonds, stock, mutual funds, real estate (attach additional page if needed)

TYPE OF ASSET	VALUE OF ASSET	INTEREST/DIVIDEND RECEIVED
	$	
	$	
	$	
REAL ESTATE	**$**	
TOTAL ASSETS	**$**	

RENTAL INFORMATION

Please list any rental information for the last 5 years (attach additional page if needed)

If you have owned your home for the past 5 years, please check here ☐ and go on to the next section.

Name of Present Landlord	Telephone Number	
Address	Dates you have lived at present address FROM: TO:	
City	State	Zip Code
Reason for leaving:		

1st Applicant's HEALTH CARE INFORMATION

*** *For Assisted Living, Memory Care and Enhanced Care Residents only ****

Please list your provider for each professional service below (attach additional providers as needed)

Primary Clinic	Telephone Number
Primary Physician	Telephone Number
Hospital	Telephone Number
Pharmacy	Telephone Number
Home Health Care	Telephone Number
Other Health Care Provider	Telephone Number

By initialing each line below, I authorize Loren on Park to contact the above-named person(s) and organizations for the following purposes:

_____ To release or disclose to Loren on Park and/or its designee all medical records or other information regarding any treatment, inpatient and/or outpatient care I have received from such health provider

_____ To use facsimile copy or photo copy of this form to send to health providers as a release of information

**I understand that this authorization, except for action already taken, may be voided by me at any time in writing and will expire in any event in one year.

2nd Applicant's HEALTH CARE INFORMATION if applicable

*** *For Assisted Living, Memory Care and Enhanced Care Residents only ****

Please list your provider for each professional service below (attach additional providers as needed)

Primary Clinic	Telephone Number
Primary Physician	Telephone Number
Hospital	Telephone Number
Pharmacy	Telephone Number
Home Health Care	Telephone Number
Other Health Care Provider	Telephone Number

By initialing each line below, I authorize Loren on Park contact the above-named person(s) and organizations for the following purposes:

_____ To release or disclose to Loren on Park and/or its designee all medical records or other information regarding any treatment, inpatient and/or outpatient care I have received from such health provider

_____ To use facsimile copy or photo copy of this form to send to health providers as a release of information

**I understand that this authorization, except for action already taken, may be voided by me at any time in writing and will expire in any event in one year.

RELEASE INFORMATION

I certify that all information contained in this application is true and accurate to the best of my knowledge. I authorize release of any and all information in this application to **Loren on Park** and/or its designee.

Information gathered in the application will be used to complete a background check. By signing this application, I authorize Rental History Reports (RHR) / 701 South Fifth Street, Hopkins, MN 55343 to investigate my criminal history, rental, employment and income history for the purpose of housing. The source of the information may come from but is not limited to: credit bureaus; banks and other depository institutions; federal or state records including State Employment Security Agency records: county or state criminal records or other sources as required. It is understood that a photocopy or facsimile copy of this form will serve as authorization. I understand failure to complete this form completely and truthfully may result in denial and/or forfeiture of deposit. This authorization is for this transaction only and continues in effect for one (1) year unless by state law, in which case the authorization continues in effect for the maximum period, not to exceed one (1) year, allowed by law.

_____ Signature 1st Applicant/Representative	_____ Date
Printed Name	Relationship
_____ Signature 2nd Applicant/Representative	_____ Date
Printed Name	Relationship

Please return completed application to: Loren on Park
2625 Park Ave S.
Minneapolis, MN 55407

For internal use only:
Received by:_____ Date:_____
Background Check Complete_____ Financial Review Complete_____ Rental Review Complete_____
☐ Approved ☐ Denied Date Applicant Notified: _____