Date_____ Time _____

Name of Resident seeking Room _____

Name of Guardian _____

Phone Number _____

Date of Birth _____

Current Address _____

Means of Income _____

Do you have Medicare or Medicaid?_____

Are you able to Take Care of Yourself _____

Why do you want to Live At the DCR?_____

_____

What needs do you look for us to meet at DCR?

_____

_____

Medical History?_____

_____

_____

Have you lived in a Group home Before?

_____

_____

Do we have permission to contact your Doctor concerning your medical history? _____

Please email your medical records and this form to:
admin@dcrduncan.com