re:assuredadvocacy
HEALTHCARE NAVIGATION

# Senior Living Options

**To help us better understand your needs, please indicate which services are important to you.**

Date _____

Name _____
FIRST LAST

**Type of Senior Living Community**

- ☐ Independent Living
- ☐ Assisted Living
- ☐ Skilled Nursing Facility (SNF)
- ☐ Memory Care Unit
- ☐ Continuing Care Retirement Communities (CCRC)

**Number of bedrooms** _____

**Amenities**

- ☐ Meals/dining services available If yes, number of meals per day _____
- ☐ Group transportation (grocery etc)
- ☐ Full kitchen
- ☐ Kitchenette
- ☐ Group outings (museums, theater, dinners)
- ☐ Transportation for doctor/dental appointments
- ☐ Hair salon and or barber
- ☐ Dedicated parking for resident
- ☐ Housekeeping
- ☐ Laundry service
- ☐ In-room washer and dryer
- ☐ Accepts pets If yes, what type of pet _____
- ☐ Overnight guest accommodations for visitors
- ☐ Storage

**Resident Activities**

- ☐ Exercise equipment and or classes
- ☐ Worship services
- ☐ On-site events such as guest speakers, movies and games
- ☐ Outdoor seating and or walking area.

**Health services**

- ☐ Assistance with activities of daily living (dressing, bathing, eating, using the toilet, transferring)
- ☐ Medication administration
- ☐ Therapy services (PT/OT)

**What other issues or needs should we be aware of?**