

MEDICAL REFERENCE

| | |
|------------------------|------------|
| Office Use Only | |
| Name _____ | |
| Date _____ | Time _____ |

Please provide information for our Applicant's request for residency at *The Pines, A Retirement Community for Independent Living.*



1. Circle the role with which you serve our Applicant.

Physician **PA** **Nurse** **Other** _____

2. Based on the definition for persons with disabilities, (see attached) does the Applicant qualify as Elderly or Non-elderly person with disabilities **YES** **NO**

3. Does our Applicant require handicap accessibility features in an apartment based on the definition for persons with disabilities (see attached)? **YES** **NO**

4. Does the applicant currently have a service animal? **YES** **NO**

5. Does the applicant require a live-in aide? **YES** **NO**

6. Is the applicant current with all accounts and co-pays? **YES** **NO**

Additional comments:

PHYSICIAN PLEASE COMPLETE

| | |
|-------------|----------------|
| Signature: | _____ |
| Print name: | _____ |
| Address: | _____ _____ |
| Phone: | _____ |