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# Rooming, Inc Admissions Packet

Po Box 5551 Scottsdale AZ 85261

602-348-2174

Roominginc@hotmail.com [www.10greatestcompanies.com](http://www.10greatestcompanies.com)



# ROOMING, INC

## PART I: APPLICANT'S INFORMATION

Applicant's Social Security Number: \_\_\_\_\_

Applicant's Medical Assistance Number: \_\_\_\_\_

\_\_\_\_ Federal \_\_\_\_ State Start date: \_\_\_\_/\_\_\_\_/\_\_\_\_ End date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Last \_\_\_\_\_ First \_\_\_\_\_ M.I. \_\_\_\_\_

Applicant's Permanent Mailing Address:

\_\_\_\_\_  
P. O. Box No. \_\_\_\_\_ Apt. No. \_\_\_\_\_ City \_\_\_\_\_  
State \_\_\_\_\_ Zip Code \_\_\_\_\_

Applicant's Telephone Number: (\_\_\_\_) \_\_\_\_\_

Signature of Person Completing Application \_\_\_\_\_ Date: \_\_\_\_\_

Applicant's Date of Birth: Month: \_\_\_\_\_ Day: \_\_\_\_\_ Year: \_\_\_\_\_

Applicant's sex: \_\_\_\_\_ Male \_\_\_\_\_ female

Applicant's Race: \_\_\_\_\_ (1) Black \_\_\_\_\_ (2) White \_\_\_\_\_ (3)

Native American \_\_\_\_\_ (4) Asian \_\_\_\_\_ (5) Other

Applicant's Marital Status: \_\_\_\_\_ (1) Single \_\_\_\_\_ (2) Married \_\_\_\_\_ (3) Divorced \_\_\_\_\_  
(4) Widowed \_\_\_\_\_

Applicant's Mobility: \_\_\_\_\_ (1) Walks independently \_\_\_\_\_ (2) Walks with supportive devices \_\_\_\_\_  
(3) Walks unaided with difficulty \_\_\_\_\_ (4) In wheelchair operated by self \_\_\_\_\_ (5) In wheelchair &  
needs help \_\_\_\_\_ (6) No mobility

Applicant's ability to communicate:

\_\_\_\_ (1) Speaks and can be understood \_\_\_\_\_ (2) Speaks and is difficult to understand \_\_\_\_\_ (3) Uses  
gestures \_\_\_\_\_ (4) Uses Sign Language \_\_\_\_\_ (5) Uses communication board or device \_\_\_\_\_ (6) None

Applicant's skill in activities of daily living:

Completely Independent \_\_\_\_\_

Needs assistance with:

A. Eating..... \_\_\_\_\_

B Dressing..... \_\_\_\_\_

- C. Bathing..... \_\_\_\_\_
- D. Toileting..... \_\_\_\_\_
- E. Hygiene..... \_\_\_\_\_
- F. Transfers in/out of bed..... \_\_\_\_\_

Applicant's need for supervision:

- \_\_\_ (1) No supervision \_\_\_ (2) Occasional monitoring \_\_\_ (3) Minimal daily supervision
- \_\_\_ (4) Substantial daily supervision \_\_\_ (5) Continuous supervision during waking hours
- \_\_\_ (6) Continuous 24 hours per day supervision \_\_\_ (7) Not sure

Applicant's functioning level:

- \_\_\_ (0) No entry \_\_\_ (1) Mild \_\_\_ (2) Moderate \_\_\_ (3) Severe \_\_\_ (4) Profound
- \_\_\_ (5) Unknown

**PART II: CAREGIVER/GUARDIAN/NEXT-OF-KIN INFORMATION**

The primary caregiver is the person responsible for the applicant's daily care. If the applicant is in a residential facility, put down the name of the contact person.

Primary caregiver's name: \_\_\_\_\_ Last, First

Primary caregiver's permanent mailing address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

City

State

Zip Code

Telephone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to applicant: \_\_\_ (1) Parent \_\_\_ (2) Spouse \_\_\_ (3) Self \_\_\_ (4) Not related  
 \_\_\_ (5) Public/Private Agency

**NEXT-OF-KIN**

If the next-of-kin is not the primary caregiver or the legal guardian appointed by the court, complete the following section:

Next-of-kin's name: \_\_\_\_\_

Next-of-kin's permanent mailing address: \_\_\_\_\_

P. O. Box No. Apt. No. \_\_\_\_\_

City State Zip Code \_\_\_\_\_

Telephone: (\_\_\_\_\_) \_\_\_\_\_

Relationship to applicant: \_\_\_\_ (1) Parent \_\_\_\_ Self (2) \_\_\_\_ (3) Spouse \_\_\_\_ (4) Other relative  
(5) other \_\_\_\_\_

-----

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Scottsdale, AZ 85261  
602-348-2174  
roominginc@hotmail.com

# BASIC SERVICES

A. To ensure a safe and healthful living environment for all residents the following basic services must be available. The services actually provided will be those the resident wants and those the resident needs, based on the individual's pre-admission appraisal, and the needs and services plan. Subsequent resident appraisals may result in the need for additional basic services.

B. Basic services at a minimum include:

- (1) Continuous care and supervision;
- (2) Observation for changes in physical, mental, emotional, and social functioning; and
- (3) Notification to resident's family, physician, and other appropriate person/agency of Resident's needs.
- (4) Lodging: \_\_\_\_\_ single room \_\_\_\_\_ double room
- (5) Food Services: **(Provided by Nothing Butt)**
  - \_\_\_\_\_ 1. Three nutritious meals daily and snacks.
  - \_\_\_\_\_ 2. Special diets if prescribed by a doctor.
  - \_\_\_\_\_ 3. Other meal services described as follows: \_\_\_\_\_

(If additional space is needed, attach signed and dated sheet.)

(6) Helping gain access to supportive services as follows: \_\_\_\_\_

(If additional space is needed, attach signed and dated sheet.)

**NOTE:** "Responsible person" means that individual or individuals, including a relative, health care surrogate decision maker, or placement agency, which assist the resident in placement or assume varying degrees of responsibility for the resident's well-being.

(7) \_\_\_\_\_ Plan, arrange and/or provide for transportation to medical and dental appointments as follows (Provided by rideemtaxi): \_\_\_\_\_

(If additional space is needed, attach signed and dated sheet.)

(8) \_\_\_\_\_ A planned activity program including arrangement for utilization of available Community resources as follows: \_\_\_\_\_

(If additional space is needed, attach signed and dated sheet.)

(9) \_\_\_\_\_ Assistance with personal activities of daily living as follows:  
\_\_\_\_\_ eating,  
\_\_\_\_\_ grooming,  
\_\_\_\_\_ mobility tasks, and  
\_\_\_\_\_ other personal care needs: \_\_\_\_\_

(If additional space is needed, attach signed and dated sheet.)

Additional basic services that the resident needs or wants, and that will be provided by the facility, include those checked below:

(10) \_\_\_\_\_ Hygiene items of general use, such as soap and toilet paper.

- (11) \_\_\_\_ Laundering personal clothing.
- (12) \_\_\_\_ Clean bed and bath linens weekly, or as often as needed.
- (13) \_\_\_\_ Cleaning of resident's room
- (14) \_\_\_\_ Comfortable and suitable bed and bedroom furniture.
- (15) \_\_\_\_ Assistance in meeting necessary medical and dental needs as follows:

---

(If additional space is needed, attach signed and dated sheet.)

(16) \_\_\_\_ Assistance with taking prescribed and over-the-counter medications in accordance with physician's instructions unless prohibited by law or regulations.

**(Provided by Healing Star)**

(17) \_\_\_\_ Bedside care and tray service for minor temporary illnesses or recovery from surgery.

(18) \_\_\_\_ Maintenance or supervision of resident cash resources as follows:

---

(If additional space is needed, attach signed and dated sheet.)

**SIGNATURES**

The signature of the resident and/or responsible person indicates that he/she has read, or had read and explained to him/her. The form must be dated and signed, acknowledging the contents, by the resident and/or responsible person if any, and the licensee, or designated representative upon admission.

RESIDENT: \_\_\_\_\_ Date \_\_\_\_\_

RESIDENT'S RESPONSIBLE PERSON OR CONSERVATOR: (IF APPLICABLE)

\_\_\_\_\_ Date \_\_\_\_\_

LICENSEE/FACILITY REPRESENTATIVE:

\_\_\_\_\_ Date \_\_\_\_\_

Rooming, Inc.

Healing Star

Nothing Butt

Po Box 5551

Po Box 5551

Po Box 5551

Scottsdale AZ

Scottsdale AZ

Scottsdale AZ

85326

85326

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[roominginc@hotmail.com](mailto:roominginc@hotmail.com)

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[nothingbutt@hotmail.com](mailto:nothingbutt@hotmail.com)

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# Consent for Emergency Medical Treatment-Needs assessed by Healing Star

Resident Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Address \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_

Resident's Disability \_\_\_\_\_ Date of Onset \_\_\_\_\_

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Preferred Medical Facility \_\_\_\_\_

Does Resident have any medical condition(s) requiring special precautions or treatments and any medications and dosage?  Yes  No If you answered "yes," please describe:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In case of medical emergency, the undersigned authorizes Rooming Inc, acting through the person on staff who has actual care of the resident, to consent to medical, dental, and surgical treatment of the resident when the undersigned cannot be contacted. The undersigned represents to Rooming Inc, that he or she is the residents appointed emergency contact person and has been authorized by the resident to give consent to medical and dental care and surgical treatment of the resident. The undersigned authorizes any licensed physician and/or medical facility to provide any medical/surgical care and/or hospitalization for the resident, including anesthetic, which they determine necessary or advisable, pending receipt of a special consent from the undersigned.

### \*PLEASE NOTE

Although every effort will be made to avoid any type of accident or injury, **NO LIABILITY** can be accepted by Rooming Inc.

Yes, I \_\_\_\_\_ give permission to **Rooming Inc/Healing Star** the authorization to my consent for medical /dental treatment. I understand that **NO LIABILITY** can be accepted by Rooming Inc/Healing Star in the event of any accident or injury which may occur.

\_\_\_\_\_  
Signature Resident \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_  
Signature of Undersigned \_\_\_\_\_ Date \_\_\_\_\_

Resident Insurance Carrier/Medicare/Medical \_\_\_\_\_

Policy Number \_\_\_\_\_

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# General Durable Power of Attorney

I, \_\_\_\_\_, a resident of \_\_\_\_\_ Social Security Number \_\_\_\_\_ designate \_\_\_\_\_, presently residing at \_\_\_\_\_, as my attorney in fact (referred to as “the Agent”) on the following terms and conditions:

- 1) **Authority to Act.** The Agent is authorized to act for me under this Power of Attorney and shall exercise all powers in my best interests and for my welfare.
- 2) **Powers of Agent.** The Agent shall have the full power and authority to manage and conduct all of my affairs, and to exercise my legal rights and powers, including those rights and powers that I may acquire in the future, including the following:
  - i) **Collect and Manage.** To collect, hold, maintain, improve, invest, lease, or otherwise manage any or all of my real or personal property or any interest therein;
  - ii) **Buy and Sell.** To purchase, sell, mortgage, grant options, or otherwise deal in any way in any real property or personal property, tangible or intangible, or any interest therein, upon such terms as the Agent considers proper, including the power to buy United States Treasury Bonds that may be redeemed at par to pay federal estate tax and to sell or transfer Treasury securities;
  - iii) **Borrow.** To borrow money, to execute promissory notes therefor, and to secure any obligation by mortgage or pledge.
  - iv) **Business and Banking.** To conduct and participate in any kind of lawful business of any nature or kind, including the right to sign partnership agreements, continue, reorganize, merge, consolidate, recapitalize, close, liquidate, sell, or dissolve any business and to vote stock, including the exercise of any stock options and the carrying out of any buy sell agreement; to receive and endorse checks and other negotiable paper, deposit and withdraw funds (by check or withdrawal slips) that I now have on deposit or to which I may be entitled in the future in or from any bank, savings and loan, or other institution;
  - v) **Tax Returns and Reports.** To prepare, sign, and file separate or joint income, gift, and other tax returns and other governmental reports and documents; to consent to any gift; to file any claim for tax refund; and to represent me in all matters before the Internal Revenue Service;

- vi) **Safe Deposit Boxes.** To have access to any safety deposit box registered in my name alone or jointly with others, and to remove any property or papers located therein;
  - vii) **Proxy Rights.** To act as my agent or proxy for any stocks, bonds, shares, or other investments, rights, or interests I may now or hereafter hold;
  - viii) **Legal and Administrative Proceedings.** To engage in any administrative or legal proceedings or lawsuits in connection with any matter herein;
  - ix) **Transfers in Trust.** To transfer any interest I may have in property, whether real or personal, tangible or intangible, to the trustee of any trust that I have created for my benefit;
  - x) **Delegation of Authority.** To engage and dismiss agents, counsel, and employees, in connection with any matter, upon such terms as my agent determines;
  - xi) **Restrictions on Agent's Powers.** Regardless of the above statements, my agent (1) cannot execute a will, a codicil, or any will substitute on my behalf; (2) cannot change the beneficiary on any life insurance policy that I own; (3) cannot make gifts on my behalf; and (4) may not exercise any powers that would cause assets of mine to be considered taxable to my agent or to my agent's estate for purposes of any income, estate, or inheritance tax, and (5) cannot contravene any medical power of attorney I have executed whether prior or subsequent to the execution of this Power of Attorney.
- 3) **Durability.** This durable Power of Attorney shall be irrevocable until the trust corpus is surrendered by the trustees, shall not be affected by my death or disability except as provided by law, and shall continue in effect after the surrender of the trust corpus until my death or until revoked by me in writing.
- 4) **Reliance by Third Parties.** Third parties may rely upon the representations of the Agent as to all matters regarding powers granted to the Agent. No person who acts in reliance on the representations of the Agent or the authority granted under this Power of Attorney shall incur any liability to me or to my estate for permitting the Agent to exercise any power prior to actual knowledge that the Power of Attorney has been revoked or terminated by operation of law or otherwise.
- 5) **Indemnification of Agent.** No agent named or substituted in this power shall incur any liability to me for acting or refraining from acting under this power, except for such agent's own misconduct or negligence.
- 6) **Original Counterparts.** Photocopies of this signed Power of Attorney shall be treated as original counterparts.
- 7) **Revocation.** I hereby revoke any previous Power of Attorney that I may have given to deal with my property and affairs as set forth herein.

8) **Compensation.** The Agent shall be reimbursed for reasonable expenses incurred while acting as Agent and may receive reasonable compensation for acting as Agent.

9) **Substitute Agent.** If \_\_\_\_\_ is, at any time, unable or unwilling to act, I then appoint \_\_\_\_\_, presently residing at \_\_\_\_\_ as my Agent.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Resident Signature

Signed in the presence of:

\_\_\_\_\_  
[WITNESS]

\_\_\_\_\_  
[WITNESS]

Subscribed and sworn to before me on \_\_\_\_\_.

\_\_\_\_\_ Notary Public,  
\_\_\_\_\_ My commission expires \_\_\_\_\_.  
(County & State)

Rooming, Inc                      602-348-2174  
Po Box 5551  
[www.10greatestcompanies.com](http://www.10greatestcompanies.com)

[roominginc@hotmail.com](mailto:roominginc@hotmail.com)  
Scottsdale, AZ  
85261

## NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT AND CONSENT

This notice of Privacy Practices tells you how we ROOMING, INC may use and share your health records.

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy of your health records
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights can be explained in more detail if need be.

I agree to allow Rooming Inc to share or use my health records.

Signature: \_\_\_\_\_ Date \_\_\_\_\_  
(of Resident or Legal Representative)

Capacity of Legal Representative (if applicable) \_\_\_\_\_

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Scottsdale AZ  
85261

# IDENTIFICATION AND EMERGENCY INFORMATION

This information is required under the regulations of the Department to be maintained on every person admitted to Rooming Inc, to be readily available to the person in charge, but not accessible to unauthorized persons. All information must be kept current. **(PLEASE ATTACH ALL PHOTOS AT THE END OF THIS FORM)**

1. NAME OF RESIDENT (PHOTO NEEDED)

\_\_\_\_\_

2. RESPONSIBLE PERSON OR PLACEMENT AGENCY \_\_\_\_\_

3. NAME OF NEAREST RELATIVE (OPTIONAL) \_\_\_\_\_

4. DATE ADMITTED TO ROOMING INC \_\_\_\_\_

5. PHYSICIAN \_\_\_\_\_

6. MENTAL HEALTH PROVIDER, IF ANY \_\_\_\_\_

7. DENTIST \_\_\_\_\_

8. RELATIVE(S) \_\_\_\_\_

9. FRIEND(S) \_\_\_\_\_

10. AMBULATORY STATUS \_\_\_\_\_

11. RELIGIOUS PREFERENCE \_\_\_\_\_

COMMENTS:

\_\_\_\_\_  
\_\_\_\_\_

SIGNATURE OF RESIDENT

\_\_\_\_\_

SIGNATURE OF PERSON COMPLETING FORM \_\_\_\_\_

DATE \_\_\_\_\_

NAME AND ADDRESS OF CLERGYMAN OR RELIGIOUS ADVISOR, IF ANY \_\_\_\_\_

TELEPHONE \_\_\_\_\_

NAME OF HOSPITAL TO BE TAKEN IN AN EMERGENCY \_\_\_\_\_

ADDRESS OF HOSPITAL TO BE TAKEN IN AN EMERGENCY \_\_\_\_\_

MEDICAL PLAN IDENTIFICATION NUMBER \_\_\_\_\_

DENTAL PLAN NUMBER (IF ANY) \_\_\_\_\_

MEDICAL PLAN \_\_\_\_\_

NAME OF DENTAL PLAN (IF ANY) \_\_\_\_\_

SOCIAL SECURITY NUMBER (PHOTO NEEDED) \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

AGE \_\_\_\_\_

SEX \_\_\_\_\_

**NAME OF EMERGENCY CONTACT** \_\_\_\_\_

**RELATIONSHIP** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

TELEPHONE \_\_\_\_\_ CELL # \_\_\_\_\_

COMMENTS:  
(IF ANY) \_\_\_\_\_

***\*NAME AND PHONE NUMBER OF PERSON TO CONTACT, IF AUTHORIZED  
REPRESENTATIVE IS NOT  
AVAILABLE \_\_\_\_\_***

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# Weekly Medicine Chart-Healing Star

*Use this form to help residents keep track of his or her medications.*

## How to Use your Weekly Medicine Record

Here's a handy record to help your residents keep track of what medicines to take every day, when to take them, and when he or she took them.

Write name and date, starting on Sunday, at the top of the record.

Each numbered row is for one medicine. Take the name and dosage of each medicine and from the label on each container and write them under the first column.

In the second column, write the size, shape and color of the pill. For example: Small, round, white pill.

In the third column, write when to take the medicine. For example: Before breakfast.

When your resident takes a medicine, place an "X" in the column for the day of the week. If your resident takes a medicine more than once a day, mark it each time.

**Name:** \_\_\_\_\_

**Week of:** \_\_\_\_\_

Name & Dosage of Medicine	Size, Shape, Color of the Pill	When to take Medicine	Sun	Mon	Tue	Wed	Thu	Fri	Sat

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# Medication Intake Form

## Healing Star

Please print or type:

Applicant's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone#: (\_\_\_\_) \_\_\_\_\_ Male Female Marital Status: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**CURRENT MEDICATIONS:**

Medication	Dose	Route	Schedule	How Long?

Any PRN medications and for what target symptoms:

Medication	Dose	Route	How Often	For

Physician Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone Number: (\_\_\_\_) \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Names of other supporting professionals: \_\_\_\_\_

\_\_\_\_\_  
Name

Telephone Number

\_\_\_\_\_  
Name

Telephone Number

**ADDITIONAL NOTES AND COMMENTS:**

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[healingstar@hotmail.com](mailto:healingstar@hotmail.com)

# Weekly Food Intake- Healing Star

Week of: \_\_\_\_\_

**Sunday Monday Tuesday Wednesday Thursday Friday Saturday**

**Supplements** \_\_\_\_\_

**Breakfast** \_\_\_\_\_

**Snack** \_\_\_\_\_

**Lunch** \_\_\_\_\_

**Snack** \_\_\_\_\_

**Dinner** \_\_\_\_\_

**Notes:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\*Please note: We will try and accommodate any resident who has a special diet as best as we can

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# PROPERTY INVENTORY FORM

Date \_\_\_\_\_

Resident Name \_\_\_\_\_

**Reason for Inventory:**

Admit \_\_\_\_\_

Move Out \_\_\_\_\_

Other Property List and quantity of each item

Arts/Crafts/Paper	Electrical Power Bar (1)	Photo Album (1)
Athletic Shoes (1)	Emery Boards** (2)	Picture Frame (8"x10") (1)
Athletic Supporters (1-2)	Fingernail Clippers (1)	Plastic Coffee Cup (1)
	Footwear (1) [if no athletic shoes]	Plastic Drinking Cup (1)
Baseball/Stocking Cap (1-2)	Gym/Walking Shorts (1-2)	Playing Cards (1 Set)
Bathrobe* (1)		Postage Stamps (20)
Personal Jeans (5)		Ring (1 plain wedding band—no stones)
		Sewing Kit (1)
Personal Shirts (5)		
Hair Clip** (1)	Shower Shoes (1)	
Hair Rollers** (20)	Headsets (2)	Soap Dish (1)
Bowl with Lid (1)	Ice Bucket (1)	Socks (7)
Bras** (7)	Inmate ID (1)	Spoon (1)
Briefs/Boxer Shorts (7)	Legal Material (1 cubic foot)	Sweat suits (1-2)
Brush/Comb/Pick (1-2)		T-Shirt, State Issue (1)
	Makeup Bag** (1)	T-Shirt, Commemorative
Combination Padlocks (2)	Nicotine Patches (1 Series)	

Baseball/Stocking Cap (1-2)

Gym/Walking Shorts (1-2)    Playing Cards

Baseball/Stocking Cap (1-2)

Gym/Walking  
Shorts (1-2)    Playing  
Cards  
(1 Set)

Bathrobe\* (1)

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# RECORD OF RESIDENT'S SAFEGUARDED CASH RESOURCES

**Resident:** Your signature below indicates you have received the following amount of money from the facility on the date indicated.

Facilities that handle resident's cash resources must maintain accurate records of all money received and disbursed.

## **INSTRUCTIONS:**

- 1) The date of the transaction shall be noted under Date.
- 2) Use a separate line for each transaction.
- 3) Supporting receipts for purchases shall be filed in order of dates of purchases.
- 4) The resident's (or resident's representative) signature on this form may serve as a receipt for cash distribution to the resident.
- 5) The facility representative's signature is necessary to be able to verify a cash transaction.

**NAME OF RESIDENT** \_\_\_\_\_  
**DATE** \_\_\_\_\_  
**DESCRIPTION AMOUNT** \_\_\_\_\_  
**RECEIVED** \_\_\_\_\_  
**AMOUNT SPENT OR WITHDRAWN** \_\_\_\_\_  
**BALANCE** \_\_\_\_\_

**SIGNATURE FOR CASH TRANSACTIONS** \_\_\_\_\_

**FACILITY REPRESENTATIVE RESIDENT  
OR REPRESENTATIVE** \_\_\_\_\_

**DATE** \_\_\_\_\_

Rooming, Inc.  
Po Box 5551  
Scottsdale AZ

Cash your way  
Po Box 5551  
Scottsdale AZ

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[roominginc@hotmail.com](mailto:roominginc@hotmail.com)

85261

[cashyourway@hotmail.com](mailto:cashyourway@hotmail.com)

# ATTENDANT CARE/HOUSEKEEPING

RESIDENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

## HOUSEKEEPING

## FREQUENCY ESTIMATE

Kitchen

Floor

Counter tops

Outside cabinets

Wash dishes Hand Dishwasher

Dry dishes Hand Dishwasher

Store dishes

Clean refrigerator

Other (*Specify*)

Living room/Dining room

Floor

Dust (*e.g., tables, furniture*)

Other (*Specify*)

Miscellaneous Duties

Take out garbage (*Curb side only*)

Wash laundry Hand Machine

Dry laundry Hand Machine

Fold laundry

Shopping for food and household

Other (*Specify*)

COMMENTS/SPECIALIZED INSTRUCTIONS (*e.g., list cleaning methods - vacuum, sweep, mop, scour with cleanser, disinfect, wipe down with cleaner,*

etc: \_\_\_\_\_

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Rooming, Inc Po Box 5551 Scottsdale AZ 85261 [roominginc@hotmail.com](mailto:roominginc@hotmail.com) 602-348-2174  
[www.10greatestcompanies.com](http://www.10greatestcompanies.com)

# FACILITY VISITING POLICY

## Guest information form

A. Rooming, Inc encourages family visits and communication. Regular family involvement with the resident is encouraged. We want to provide the opportunity for family participation in facility activities.

B. Facility visiting hours are \_\_\_\_\_ .

Our policy concerning visits is:

\_\_\_\_\_

\_\_\_\_\_

C. Our policy concerning other communication with residents is:

\_\_\_\_\_

\_\_\_\_\_

D. When receiving visitors please take down:

Name \_\_\_\_\_

E-mail address \_\_\_\_\_

License plate # \_\_\_\_\_

Phone Number \_\_\_\_\_

Rooming Inc

Sharing a Room

Protecting Rooms

Po Box 5551

Po Box 5551

Po Box 5551

Scottsdale AZ

Scottsdale AZ

Scottsdale

85261

85261

85261

[roominginc@hotmail.com](mailto:roominginc@hotmail.com)   [sharearoom@hotmail.com](mailto:sharearoom@hotmail.com)   [protectingrooms@hotmail.com](mailto:protectingrooms@hotmail.com)

[www.10greatestcompanies.com](http://www.10greatestcompanies.com)

602-348-2174



ROOMING, INC

Po Box 5551 Scottsdale AZ 85261-5551

# FIRST PAYMENT SERVICES

Auto Pay Application

6/2/2008

PLEASE CIRCLE:

NEW    UPGRADE OR REPLACEMENT    IN ADDITION TO PREVIOUS    CHANGE TO  
BANK ACCOUNT

Tenant Name: \_\_\_\_\_ Telephone \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Bank Name: \_\_\_\_\_

I authorize withdrawals from the designated account, with a start date of:  
\_\_\_\_\_, in the amount of: \_\_\_\_\_, until I cancel  
said withdrawals.

Any additional arrangements, such as different amount for first payment or payments other than  
monthly:

---

I understand that it is my responsibility to assure that adequate funds are in the designated account on the due-date(s). I also understand that I am in full control of my payments. If at any time I decide to discontinue or alter this payment method, I need only notify Rooming, Inc. a minimum of five working days before the payment date.

ATTACH VOIDED CHECK

(Be sure numbers along bottom of check are clear and readable)

---

Signature as used when signing checks

Date

## ***Rooming Program***

Month-to-Month Lease Agreement for Furnished Room

Date: \_\_\_\_\_, 20\_\_\_\_\_

RECEIPT IS ACKNOWLEDGED by Share A Room, hereinafter referred to as "Management"

From \_\_\_\_\_, hereinafter referred to as "Resident", the sum of \$\_\_\_\_\_ deposit, and the sum of \$\_\_\_\_\_ for the first month's rent of the premises, owned by Management, and located at 1602 W. McDowell Rd, Phoenix, AZ 85007, hereinafter referred to as "the premises". Management agrees to rent premises to resident on a month-to-month basis at a rental basis of \$\_\_\_\_\_ per month, payable in advance on the \_\_\_\_\_ day of each month.

In consideration hereof, and the use or occupancy of the said premises, resident agrees:

1. To maintain the premises in a clean, orderly and law-abiding manner and to keep the yards thereof free of weeds, debris, and/or material that may become unsightly or a detriment to the appearance of said premises. Management shall have the right to enter and inspect said premises at any reasonable times.
2. That no alterations or redecorating of any kind to the dwelling shall be made without the prior written consent of Management.
3. To pay the cost of all repairs for any damage done by resident to said premises which Management may consider necessary.
4. That no birds, animals, or other pets shall be kept in the premises.
5. Not to let or sublet the whole or any part of the premises to anyone for any purpose whatever without prior written permission from Management.
6. To give seven (7) days notice to Management prior to vacating the premises and to permit prospective tenants the opportunity of reasonable inspection.
7. To clean the premises upon vacating and restore the premises to the same condition they are now in, reasonable wear and tear and damage by the elements excepted.
8. That the violation of any of the covenants of the agreement or the non-payment of any rents due and unpaid shall be sufficient for eviction from said premises upon two (2) days written notice.

9. To pay all costs owing including rent, removal of furnishings or other items belonging to Management, and repairs of damages to premises.
10. All amounts due will be paid prior to move-out. Any amounts still owed will be deducted from Resident's deposit.
11. All rents shall be paid at the location designated by Management
12. Resident has read, acknowledged and signed the "House Rules". (Initials\_\_\_\_\_)
13. Proof of social security income

No waiver will be made by Management at any time of any of the terms of this agreement. Resident acknowledges receipt of a copy of this agreement.

Resident Name (printed) \_\_\_\_\_  
 Residents Signature \_\_\_\_\_  
 Case Worker Name (printed) \_\_\_\_\_  
 Contact Phone \_\_\_\_\_  
 Office Phone \_\_\_\_\_ Extension \_\_\_\_\_  
 Resident's SSAN \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Received by (Printed Name) \_\_\_\_\_  
 Signed by \_\_\_\_\_

Mail Payment To:  
 Rooming, Inc.  
 Po Box 5551  
 Scottsdale, AZ 85261

\*For quick payment go to any Bank of America use account # 4370026228  
 \*For quick payment go to any Washington Mutual use account # 3160351925

For nearest Bank of America call-  
 For nearest Washington Mutual call-

For directions use [www.mapquest.com](http://www.mapquest.com)  
 If you need transportation please go to rideemtaxi@hotmail.com

QUESTIONS? PLEASE CALL:

Contact: Mr. Elijah Brown

ID# \_\_\_\_\_

Cell #: 602-348-2174

Business #: 602-274-0560

Email: [elijahbrown43@msn.com](mailto:elijahbrown43@msn.com)

notarized

Email: [roominginc@hotmail.com](mailto:roominginc@hotmail.com)

[www.10greatestcompanies.com](http://www.10greatestcompanies.com)

Agent

This document must be

Rooming, Inc Po Box 5551 Scottsdale, AZ 85261-5551 (602) 348-2174  
www.10greatestcompanies.com, roominginc@hotmail.com

# FIRST PAYMENT SERVICES

Auto Pay Application

6/2/2008

PLEASE CIRCLE:

NEW    UPGRADE OR REPLACEMENT    IN ADDITION TO PREVIOUS    CHANGE TO  
BANK ACCOUNT

Tenant Name: \_\_\_\_\_ Telephone \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Bank Name: \_\_\_\_\_

I authorize withdrawals from the designated account, with a start date of:  
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Any additional arrangements, such as different amount for first payment or payments other than  
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ATTACH VOIDED CHECK

(Be sure numbers along bottom of check are clear and readable)

\_\_\_\_\_  
Signature as used when signing checks

\_\_\_\_\_  
Date

## ***Rooming Program***

Week-to-Week Lease Agreement for Furnished Room

Date: \_\_\_\_\_, 20\_\_\_\_\_

RECEIPT IS ACKNOWLEDGED by Share A Room, hereinafter referred to as "Management"

From \_\_\_\_\_, hereinafter referred to as "Resident", the sum of \$\_\_\_\_\_ deposit, and the sum of \$\_\_\_\_\_ for the first month's rent of the premises, owned by Management, and located at 1602 W. McDowell Rd, Phoenix, AZ 85007, hereinafter referred to as "the premises". Management agrees to rent premises to resident on a week-to-week basis at a rental basis of \$\_\_\_\_\_ per month, payable in advance on the \_\_\_\_\_ day of each month.

In consideration hereof, and the use or occupancy of the said premises, resident agrees:

1. To maintain the premises in a clean, orderly and law-abiding manner and to keep the yards thereof free of weeds, debris, and/or material that may become unsightly or a detriment to the appearance of said premises. Management shall have the right to enter and inspect said premises at any reasonable times.
2. That no alterations or redecorating of any kind to the dwelling shall be made without the prior written consent of Management.
3. To pay the cost of all repairs for any damage done by resident to said premises which Management may consider necessary.
4. That no birds, animals, or other pets shall be kept in the premises.
5. Not to let or sublet the whole or any part of the premises to anyone for any purpose whatever without prior written permission from Management.
6. To give seven (7) days notice to Management prior to vacating the premises and to permit prospective tenants the opportunity of reasonable inspection.
7. To clean the premises upon vacating and restore the premises to the same condition they are now in, reasonable wear and tear and damage by the elements excepted.
8. That the violation of any of the covenants of the agreement or the non-payment of any rents due and unpaid shall be sufficient for eviction from said premises upon two (2) days written notice.

9. To pay all costs owing including rent, removal of furnishings or other items belonging to Management, and repairs of damages to premises.
10. All amounts due will be paid prior to move-out. Any amounts still owed will be deducted from Resident's deposit.
11. All rents shall be paid at the location designated by Management
12. Resident has read, acknowledged and signed the "House Rules". (Initials\_\_\_\_\_)
13. Proof of social security income

No waiver will be made by Management at any time of any of the terms of this agreement. Resident acknowledges receipt of a copy of this agreement.

Resident Name (printed) \_\_\_\_\_  
 Residents Signature \_\_\_\_\_  
 Case Worker Name (printed) \_\_\_\_\_  
 Contact Phone \_\_\_\_\_  
 Office Phone \_\_\_\_\_ Extension \_\_\_\_\_  
 Resident's SSAN \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Received by (Printed Name) \_\_\_\_\_  
 Signed by \_\_\_\_\_

Mail Payment To:  
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 Po Box 5551  
 Scottsdale, AZ 85261

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 4370026228

\*For quick payment go to any  
**Washington Mutual** use account  
 #  
 3160351925

For nearest Bank of America call- 1-800-432-1000  
 For nearest Washington Mutual call- 1-800-788-7000

For Directions use [www.mapquest.com](http://www.mapquest.com)  
 If you need transportation please contact rideemtaxi@hotmail.com

QUESTIONS? PLEASE CONTACT:

Contact: Mr. Elijah Brown

ID# \_\_\_\_\_

Cell #: 602-348-2174

Business #: 602-274-0560

Email: [elijahbrown43@msn.com](mailto:elijahbrown43@msn.com)

notarized

Email: [roominginc@hotmail.com](mailto:roominginc@hotmail.com)

[www.10greatestcompanies.com](http://www.10greatestcompanies.com)

Agent

This document must be

# Rooming, Inc

## *Payment Receipt*

Date: \_\_\_\_\_  
Time: \_\_\_\_\_  
Business# : \_\_\_\_\_  
Fax #: \_\_\_\_\_  
E-mail address: roominginc@hotmail.com

Resident name: \_\_\_\_\_

House Address: \_\_\_\_\_

Unit # \_\_\_\_\_

Room # \_\_\_\_\_

Date \_\_\_\_\_

(Cash) \_\_\_\_\_

(Cashier C.) \_\_\_\_\_

(Money O) \_\_\_\_\_

(Amount) \$ \_\_\_\_\_

Your next payment due on \_\_\_\_\_

***Please pay on time to avoid the late charge of \$10.00 per day***

Resident Signature: \_\_\_\_\_

Received by: \_\_\_\_\_

**ACCEPTED WITH FULL WEEKLY RENT**

