# ARLEIGH BURKE PAVILION

## Application for Move-In

**$100 Non-refundable Application fee**
**Check payable to VHC**

Name:_____
*(Last)* *(First )* *(MI)*

Address: _____

_____

Email *(optional):* _____

Gender: *(please circle)*
Male Female

Telephone Number(s):
( ) _____
( )_____

| Age: | Date of Birth: | Birth Place: | Citizenship: |
|---|---|---|---|
| | | | |

Social Security Number:

Medicare Number:

Marital Status:
☐ Married
☐ Widowed
☐ Divorced
☐ Separated
☐ Single

Military Affiliation:

_____
*(Name)* *(Relationship)*

Branch of Service:
_____
Rank:

Religious Affiliation:

Name of Pastor/Leader:

Telephone Number:
( ) _____

## Additional Insurance Information

Other Insurance: _____
*(Name)*
Policy Number: _____

Other Insurance: _____
*(Name)*
Policy Number: _____

Name of Spouse:

Telephone Number(s): ( ) _____
( )_____

## Billing Information

Bill To:

Name: _____

Address: _____

_____

Email *(optional)*:_____

**POA**
Relationship: _____ Yes / No
Telephone Number(s):
Home: ( ) _____
Work: ( ) _____
Cell: ( ) _____

*Application for Move-in Cont.* | **Name:**

## Notify in Case of Emergency (Please List Three)

**(#1)** Name: _____

Address: _____

_____

Email *(optional)*:_____

**POA**

Relationship: _____ Yes / No

Telephone Number(s):

Home: (  ) _____

Work: (  ) _____

Cell: (  ) _____

**(#2)** Name: _____

Address: _____

_____

Email *(optional)*:_____

**POA**

Relationship: _____ Yes / No

Telephone Number(s):

Home: (  ) _____

Work: (  ) _____

Cell: (  ) _____

**(#3)** Name: _____

Address: _____

_____

Email *(optional)*:_____

**POA**

Relationship: _____ Yes / No

Telephone Number(s):

Home: (  ) _____

Work: (  ) _____

Cell: (  ) _____

## Social Information

| **Special Interest / Hobbies** | **Past Occupation / Career** |
|---|---|
| | |

## Health Information

| **Attending Physician** | **Consulting Physician** |
|---|---|
| Name: _____ | Name: _____ |
| Address: _____ | Address: _____ |
| _____ | _____ |
| Telephone Number: (  ) _____ | Telephone Number: (  ) _____ |

Please list all diagnoses:

Please list all known allergies:

| ***Application for Move-in Cont.*** | **Name:** |
|---|---|

| Hospital Preference: | Funeral Home Preference: |
|---|---|

Name of Nursing Home in which you have resided: _____

Address: _____ Telephone No.(  ) _____

_____

Dates of Stay: _____ Administrator: _____

## Functional Ability

Directions: Please describe the assistance needed in the following areas.

| |
|---|
| Walking: |
| Bathing: |
| Communication: *(sight, hearing & speech)* |
| Dressing: |
| Eating: |
| Toileting: |
| Special Diets: |
| Skin Condition: |
| Additional Comments: |

## Level of Living & Length of Stay

Anticipated Level of Living: ☐ Assisted Living ☐ Healthcare Center

Anticipated Length of Stay*: ☐ Less than 30 Days ☐ 30-180 Days ☐ Long term

*Effective 7/1/07 VA state law requires long term care facilities to determine whether a prospective resident staying 3 or more days appears on the state's Sex Offender Registry. This can be accessed at http://sex-offender.vsp.virginia.gov/sor Please exercise whatever due diligence you feel is necessary with respect to information on any sex offenders registered.

| Date of Requested Move-in: | Healthcare Center Room Size Desired:<br>☐ Semi-Private ☐ Private<br>Assisted Living Suite Desired:<br>☐ Efficiency ☐ 1 Bedroom ☐ 2 Bedroom |
|---|---|

# FINANCIAL PROFILE

| **Name:** | **Phone: (  )** | |
|---|---|---|
| **Address:** _____<br>_____ | **Years at Present Address:** | ***Please Circle:***<br>**Rent Own** |

## *PLEASE PROVIDE SUPPORTING DOCUMENTATION

| **Monthly Expenses** | | ***Monthly Income** | |
|---|---|---|---|
| Mortgage | $ | Social Security | $ |
| Rent | $ | Pensions | $ |
| Utilities | $ | Investments | $ |
| Medical | $ | Interest | $ |
| Living | $ | Other | $ |
| Other | $ | | |
| **Total** | | **Total** | |

| ***Assets** | | **Liabilities** | |
|---|---|---|---|
| Cash | $ | Mortgage | $ |
| Stocks/Funds | $ | Second Trust | $ |
| Money Markets | $ | Loans | $ |
| CDs/Bonds | $ | Credit Cards | $ |
| Real Estate | $ | Other | $ |
| Life Insurance | $ | **Total** | $ |
| Burial Insurance | $ | Do you have Long-term Care Insurance? ☐ Yes ☐ No | |
| Other | $ | *Please provide copy of the Policy Declaration Page* | |
| **Total** | | $_____ per day for _____ years | |

## Agreement & Signatures

| Name of Responsible Party: | Responsible Party has the Following:<br>☐ Power of Attorney ☐ Guardianship<br>☐ Conservator |
|---|---|

I hereby certify that the information I have given is true and correct. I understand that the omission or falsification of any requested information may be grounds for discharge.

| | | |
|---|---|---|
| **Prospective Resident:** | *Signature* | Date |
| **Responsible Party:** | *Signature* | Date |
| **Power of Attorney:** | *Signature* | Date |