



# ARLEIGH BURKE PAVILION

## Application for Admission

**\$50 Application fee**  
**check payable to VHC**

Name: \_\_\_\_\_  
*(Last) (First) (MI)*

Gender: *(please circle)*

Male      Female

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

Telephone Number(s):

(    ) \_\_\_\_\_

County: \_\_\_\_\_

(    ) \_\_\_\_\_

Age: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Birth Place: \_\_\_\_\_

Citizenship: \_\_\_\_\_

Marital Status:

Married

Widowed

Divorced

Single

Social Security Number: \_\_\_\_\_

Medicare Number: \_\_\_\_\_

Military Affiliation *(not required)*: \_\_\_\_\_

Branch of Service: \_\_\_\_\_

*(Name)*

*( Relationship)*

Rank: \_\_\_\_\_

Religious Affiliation: \_\_\_\_\_

Name of Pastor/Leader: \_\_\_\_\_

Telephone Number: \_\_\_\_\_

(    ) \_\_\_\_\_

### Additional Insurance Information

Other Insurance: \_\_\_\_\_  
*(Name)*

Other Insurance: \_\_\_\_\_  
*(Name)*

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

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

Name of Spouse: \_\_\_\_\_

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

(    ) \_\_\_\_\_

### Billing Information

Bill To: \_\_\_\_\_

**POA**

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

Relationship: \_\_\_\_\_ Yes / No

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

Telephone Number(s):

Home: (    ) \_\_\_\_\_

Work: (    ) \_\_\_\_\_

Email *(optional)*: \_\_\_\_\_

Cell: (    ) \_\_\_\_\_

**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**

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

Telephone Number: (     ) \_\_\_\_\_

**Consulting Physician**

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

Telephone Number: (     ) \_\_\_\_\_

Please list all diagnoses:

Please list all known allergies:

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 Care & Length of Stay**

Anticipated Level of Care:     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 Admission  
Requested:

Healthcare Center Room Size Desired:

Semi-Private     Private

Assisted Living Suite Desired:

Efficiency     1 Bedroom     2 Bedroom

# FINANCIAL PROFILE

<b>Name:</b> _____	<b>Phone:</b> (        ) _____	
<b>Address:</b> _____ _____	<b>Years at Present Address:</b> _____	<i>Please Circle:</i> <b>Rent    Own</b>

## \*SUPPORTING DOCUMENTATION MUST BE SUPPLIED

Monthly Expenses		*Monthly Income	
Mortgage	\$ _____	Social Security	\$ _____
Rent	\$ _____	Pensions	\$ _____
Utilities	\$ _____	Investments	\$ _____
Medical	\$ _____	Interest	\$ _____
Living	\$ _____	Other	\$ _____
Other	\$ _____		
<b>Total</b>	_____	<b>Total</b>	_____

*Assets		Liabilities	
Cash	\$ _____	Mortgage	\$ _____
Stocks/Funds	\$ _____	Second Trust	\$ _____
Money Markets	\$ _____	Loans	\$ _____
CDs/Bonds	\$ _____	Credit Cards	\$ _____
Real Estate	\$ _____	Other	\$ _____
Life Insurance	\$ _____	<b>Total</b>	_____
Burial Insurance	\$ _____	Do you have Long-term Care Insurance? __Y __N	
Other	\$ _____	<i>Please provide copy of the Policy Declaration Page</i>	
<b>Total</b>	_____	\$_____per day	for _____ years

## Agreement & Signatures

Name of Responsible Party: _____	Responsible Party has the Following: <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Guardianship <input type="checkbox"/> Conservator
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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.

<b>Prospective Resident:</b>	<i>Signature</i> _____	Date _____
<b>Responsible Party:</b>	<i>Signature</i> _____	Date _____
<b>Power of Attorney:</b>	<i>Signature</i> _____	Date _____