



# THE SYLVESTERY

## Application for Move-In

Return to The Sylvestery with \$50 non-refundable application fee payable to Vinson Hall Corporation

Name: _____ <i>(Last) (First) (MI)</i>				Gender: <i>(please circle)</i> Male      Female	
Address: _____ _____				Telephone Number(s): H ( ) _____ W ( ) _____ C ( ) _____	
Email: _____				Marital Status: <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated <input type="checkbox"/> Single	
Age	Date of Birth:	Birth Place:	Citizenship:		
Social Security Number:		Medicare Number:			
Military Affiliation: _____ <i>(Name) (Relationship)</i>				Branch of Service: _____ Rank: _____	
Religious Affiliation:	Name of Pastor/Leader:		Telephone Number: ( ) _____		

### Additional Insurance Information

Other Insurance: _____ <i>(Name)</i>	Other Insurance: _____ <i>(Name)</i>
Policy Number: _____	Policy Number: _____
Name of Spouse:	Telephone Number(s): ( ) _____ ( ) _____

### Billing Information

Bill To:	<b>POA</b>
Name: _____	Relationship: _____ Yes / No
Address: _____ _____	Phone: Home: ( ) _____
Email: _____	Work: ( ) _____
	Cell: ( ) _____

**Application for Move-in Cont.**

**Name:**

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

**(#1)** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Email: \_\_\_\_\_

Relationship: \_\_\_\_\_ **POA**  
Yes / No  
Phone: Home: (     ) \_\_\_\_\_  
Work: (     ) \_\_\_\_\_  
Cell: (     ) \_\_\_\_\_

**(#2)** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Email: \_\_\_\_\_

Relationship: \_\_\_\_\_ **POA**  
Yes / No  
Phone: Home: (     ) \_\_\_\_\_  
Work: (     ) \_\_\_\_\_  
Cell: (     ) \_\_\_\_\_

**(#3)** Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Email: \_\_\_\_\_

Relationship: \_\_\_\_\_ **POA**  
Yes / No  
Phone: Home: (     ) \_\_\_\_\_  
Work: (     ) \_\_\_\_\_  
Cell: (     ) \_\_\_\_\_

**Possible Move-in Date & Length of Stay**

Anticipated Length of Stay:     Less than 30 days     30-180 Days     Long Term

Date of Requested Move-in:

**Health Information**

**Attending Physician**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Telephone Number: (     ) \_\_\_\_\_

**Consulting Physician**

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

**Social Information**

**Special Interests/Hobbies**

**Past Occupation/Career**

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

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

## 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>

### Financial Profile \*PLEASE PROVIDE SUPPORTING DOCUMENTATION

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? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	\$ _____	Please provide copy of the Policy Declaration Page \$ _____ per day for _____ years	
<b>TOTAL</b>			

### Agreement & Signatures

<b>Name of Responsible Party:</b> _____	<b>Responsible Party has the Following:</b> <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>Responsible Party:</b> _____	<b>Signature</b> _____	<b>Date</b> _____
<b>Relationship to Resident</b> _____		
<b>Power of Attorney:</b> _____	<b>Signature</b> _____	<b>Date</b> _____