ARLEIGH BURKE PAVILION

Application for Move-In

$50 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)*	Other Insurance: ______________ *(Name)*
Policy Number: ______________	Policy Number: ______________
Name of Spouse:	Telephone Number(s): ( ) __________ ( ) __________

Billing Information

Bill To:

Name: ____________________________________

Address: __________________________________

____

Email *(optional)*: ________________________

Relationship: ________________ **POA** 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: ____________________ Address: ____________________ ____________________ Telephone Number: ( ) ____________	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:

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: ☐ Semi-Private ☐ Private Assisted Living Suite Desired: ☐ Efficiency ☐ 1 Bedroom ☐ 2 Bedroom

FINANCIAL PROFILE

Name:	**Phone:** ( )	
Address: ______________________ ______________________	**Years at Present Address:**	***Please Circle:*** **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: ☐ Power of Attorney ☐ Guardianship ☐ 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