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)
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: ☐ 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