



APPLICATION FOR ADMISSION

P. O. Box 3240 Salem, VA 24153
540-380-6511 / Toll Free: 1-888-745-8008

AREA TO WHICH YOU ARE APPLYING:

- Lake Estates Knollwood Apts Ridgcrest Apts
Joseph C Thomas Center (assisted living)
The Oaks (assisted living)
Memory Care & Enrichment Center (assisted living)
Recovery & Care Center
Progressive Rehab Program Memory Care Unit

ACCOMMODATION REQUEST:

- Apartment: 1 BR 2 BR Studio/Efficiency
Cottage: 2 BR 3 BR
Private Room Semi-Private Room
Private Room Semi-Private Room

GENERAL INFORMATION:

Date

APPLICANT'S NAME (Last Name) (First Name) (MI) (Title)
Address City State Zip
County Home Phone Cell Phone
E-mail Social Security Number
Birth Date Place of Birth Sex: M F
Name of Spouse Spouse SS#
Marital Status: Single Married Widowed Divorced Separated Served in the Armed Forces? Yes No
Church Affiliation Pastor Phone #
Employment Status Occupation (Current/Previous)
If currently employed, employer name
Employer Address (Street Name) (City) (State) (Zip)
Applicant is now living in: Own Home Apartment With Relative Other (specify)

INSURANCE INFORMATION:

Medicare Number Effective Date: Part A Effective Date: Part B
Medicaid Number Effective Date
Health Insurance Company Group Number
Insurance ID Number Insured's Name Effective Date
Long-term care policy Policy ID number Effective date
Has applicant applied for Medicaid? Yes No Agency Caseworker
How does applicant plan to finance services?
Who will be responsible for handling applicant's finances? NAME
Address City State/Zip
Relationship Phone Numbers (H) (Other)

MEDICAL INFORMATION:

Primary Physician _____ Address _____ Phone # _____

Other Physician _____ Address _____ Phone # _____

Name of Dentist _____ Address _____ Phone # _____

Most recent hospitalization: Latest Admission Date _____ Latest Discharge Date _____

Name of Hospital _____ Hospital Preference: _____

Has applicant ever been admitted to a nursing home? ___ Yes ___ No Latest Admission Date _____

Name of nursing home _____ Latest Discharge Date _____

Have Funeral arrangements been made: ___ Yes ___ No

Funeral Director _____ Phone _____

Address _____ City _____ State _____ Zip Code _____

If funeral arrangements have not been made, who will make them?

Name _____ Relationship _____

Phone (day) _____ (evening) _____

Is applicant an Organ Donor? ___ Yes ___ No Any special donor arrangements? _____

Does the applicant require the use of the following? Wheelchair _____ Walker _____ Cane _____

Can the applicant: Dress himself/herself ___ Yes ___ No Bathe without assistance ___ Yes ___ No

Does the applicant have any history of: ___ Alcoholism ___ Tuberculosis ___ Drug Addiction
___ Mental Illness/Retardation (please explain) _____

Has an Advanced Medical Directive been completed? ___ Yes ___ No Has a Living Will been completed? ___ Yes ___ No

Has a Durable Medical Power of Attorney been designated? ___ Yes ___ No If yes, documentation provided? Yes ___ No ___

Name _____ Phone _____

Name _____ Phone _____

Has a Durable Financial Power of Attorney been designated? ___ Yes ___ No If yes, documentation provided? Yes ___ No ___

Name _____ Phone _____

Name _____ Phone _____

CONTACT INFORMATION:

NAME _____ **Address** _____ **Relationship** _____
(Relative/guardian responsible for applicant's personal affairs)

City _____ **State/Zip** _____ **E-mail:** _____

Phone Numbers (H) _____ **(W)** _____ **(Cell)** _____

OTHERS:

NAME _____ **Address** _____ **Relationship** _____

City _____ **State/Zip** _____

Phone Numbers (H) _____ **(W)** _____ **(Cell)** _____

NAME _____ **Address** _____ **Relationship** _____

City _____ **State/Zip** _____ **Phone (H)** _____ **(Other)** _____