Office use only: Received: _____

VALLEY VIEW
Retirement Community

Application for Residency

Applicant #1

For which area of Valley View are you applying? (You may check more than one.)

Residential Living	Personal Care	Skilled Nursing	Memory Care	Rehab
☐	☐	☐	☐	☐

Personal Data

Name _____ Email _____

Address _____ City, State, Zip _____

Home Phone _____ Mobile Phone _____

Date of Birth _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Military Veteran: ☐ Yes ☐ No Occupation (prior to retirement) _____

Spouse's Name _____ If deceased, date of death _____

Applicant #2 (If applicable)

For which area of Valley View are you applying? (You may check more than one.)

Residential Living	Personal Care	Skilled Nursing	Memory Care	Rehab
☐	☐	☐	☐	☐

Personal Data

Name _____ Email _____

Address _____ City, State, Zip _____

Home Phone _____ Mobile Phone _____

Date of Birth _____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Military Veteran: ☐ Yes ☐ No Occupation (prior to retirement) _____

Spouse's Name _____

Applicant #1

Power of Attorney _____ Relationship _____

Address _____ City, State, Zip _____

Telephone _____ Mobile Phone _____ Email _____

Type of Power of Attorney: ☐General ☐Healthcare ☐Durable ☐Bank Living Will? ☐Yes ☐No

Current Physician _____ Telephone _____ POLST? ☐Yes ☐No

Insurance Information (Upon admission, cards must be presented for verification and copying).

Medicare Number _____ Social Security Number _____

Supplemental Insurance Company _____ Group # _____

Medicare Advantage/PPO _____ Group # _____

Medicare Part D or Pharmacy Plan _____ Group # _____

Long Term Care Insurance? ☐Yes ☐No If yes, Company _____

Life Insurance? ☐Yes ☐No Cash Value $_____ Pre-paid burial reserve? ☐Yes ☐No

Applicant #2 (If applicable)

Power of Attorney _____ Relationship _____

Address _____ City, State, Zip _____

Telephone _____ Mobile Phone _____ Email _____

Type of Power of Attorney: ☐General ☐Healthcare ☐Durable ☐Bank Living Will? ☐Yes ☐No

Current Physician _____ Telephone _____ POLST? ☐Yes ☐No

Insurance Information (Upon admission, cards must be presented for verification and copying).

Medicare Number _____ Social Security Number _____

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Medicare Part D or Pharmacy Plan _____ Group # _____

Long Term Care Insurance? ☐Yes ☐No If yes, Company _____

Life Insurance? ☐Yes ☐No Cash Value $_____ Pre-paid burial reserve? ☐Yes ☐No

Optional Information

Religious Affiliation _____ Specific Congregation _____

Clergy _____ Telephone _____

Medical History for Applicant #1

To determine eligibility of insurance benefits and for regulatory compliance, complete the following:

Hospitalization Record

Were you hospitalized in the last year? ☐ Yes ☐ No

Complete the following for any hospitalization within the last year **or** for the two most recent hospitalizations.

Hospital	Inpatient/Outpatient	Dates of Hospitalization	Reason
1.			
2.			

Details on any other significant hospitalizations or surgeries: _____

_____

Hospital of choice for future hospitalizations: _____

Mental Health Record

Have you ever received mental health services? ☐ Yes ☐ No

Give details on any previous services/treatment:

Provider	Year	Inpatient/Outpatient	Services/Treatment
1.			
2.			

Nursing Home/Care Facility Record

Have you had any previous admissions to a nursing or other care facility? ☐ Yes ☐ No

Give details on any previous treatment:

Facility	Dates of Stay	Reason for Admission	Therapies Received
1.			
2.			

Therapies/Home Health Services Record

Please describe any in-home services you have used in the past year, such as Occupational, Physical, and/or Speech Therapy, Home Health Services, etc.

Provider	Dates of Service	Reason	Therapies/Services Received
1.			
2.			

Medical History for Applicant #2

To determine eligibility of insurance benefits and for regulatory compliance, complete the following:

Hospitalization Record

Were you hospitalized in the last year? ☐ Yes ☐ No

Complete the following for any hospitalization within the last year **or** for the two most recent hospitalizations.

Hospital	Inpatient/Outpatient	Dates of Hospitalization	Reason
1.			
2.			

Details on any other significant hospitalizations or surgeries: _____

_____

Hospital of choice for future hospitalizations: _____

Mental Health Record

Have you ever received mental health services? ☐ Yes ☐ No

Give details on any previous services/treatment:

Provider	Year	Inpatient/Outpatient	Services/Treatment
1.			
2.			

Nursing Home/Care Facility Record

Have you had any previous admissions to a nursing or other care facility? ☐ Yes ☐ No

Give details on any previous treatment:

Facility	Dates of Stay	Reason for Admission	Therapies Received
1.			
2.			

Therapies/Home Health Services Record

Please describe any in-home services you have used in the past year, such as Occupational, Physical, and/or Speech Therapy, Home Health Services, etc.

Provider	Dates of Service	Reason	Therapies/Services Received
1.			
2.			

Financial Statement

All questions must be answered to process the application.

Name _____ **Date** _____

Have you (or your spouse) transferred any assets, including real estate, to someone other than your spouse for less than full market value within the past five years? ☐ Yes ☐ No

Have you (or your spouse) established a trust or transferred any assets to a trust within the past five years?

☐ Yes ☐ No

If the answer is yes to either question, please use a separate sheet of paper to describe any transactions valued at more than $500 in a calendar month. This information is being requested because such transactions can interfere with and delay eligibility for Medicaid, both now and in the future.

Assets	**Applicant #1**	**Applicant #2**
Checking Account		
Savings Account		
Certificate of Deposit		
Mutual Funds		
Stocks & Bonds		
IRA – 403(b) – 401(k)		
Trust Fund		
Annuities		
Value of Business		
Loans to Others		
Other		
Total Assets		

Monthly Income	**Applicant #1**	**Applicant #2**
Social Security		
Pensions		
Annuities		
Interest/Dividends		
IRA/Bonds		
Rental Income		
Other:		
Total Monthly		

Liabilites		
Monthly Rent		
Notes Payable		
Credit Card Debt		
Other:		
Total Liabilities		

I own the above assets and they are available for payment of services I may receive at Valley View Retirement Community.

Description of Real Estate

Property & Location	**Date Acquired**	**Purchase Price**	**Mortgage Remaining**	**Fair Market Value**
1.				
2.				

I understand that Valley View Retirement Community retains the right to accept or reject any application consistent with the law. I certify that all of the information submitted on this application is true and correct, and I understand the submission of false information may constitute grounds for rejection of this application or my discharge after admission.

Signature of Applicant _____ Date _____

Signature of person completing application, if other than applicant _____

Emergency Contacts

Name	Relationship	Address	Telephone/Contact Info
		Street _____ _____ City _____ State _____ Zip _____	Home _____ Work _____ Mobile _____ Email _____
Name	**Relationship**	**Address**	**Telephone/Contact Info**
		Street _____ _____ City _____ State _____ Zip _____	Home _____ Work _____ Mobile _____ Email _____
Name	**Relationship**	**Address**	**Telephone/Contact Info**
		Street _____ _____ City _____ State _____ Zip _____	Home _____ Work _____ Mobile _____ Email _____

Other Information

How did you hear about Valley View Retirement Community?

☐ Church ☐ Hospital/Physician Recommendation ☐ Internet Search

☐ Community Event ☐ Social Media ☐ Live Locally

☐ Family/Friend is/was a Resident ☐ Publications ☐ Home Health Agency

☐ Other (please specify) _____

What is your desired time frame for moving to Valley View Retirement Community?

_____

_____

_____

VALLEY VIEW
Retirement Community

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