



**COTTAGE ADMISSION APPLICATION**

<b>Valley View Retirement Community</b>
4702 East Main Street
Belleville, PA 17004
PH: (717) 935-2105 • Fax: (717) 935-5109

**APPLICATION FOR A COTTAGE AT :**

Valley View Retirement Community Belleville, PA
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The information asked for in this application is needed to evaluate the applicant's request for residency. All information will be considered by the Admissions Committee and will be held in strict confidence. The acceptance of this application does **not** bind either party to admission. Failure to complete the application in its entirety could result in denial of consideration for admission. When two individuals apply together, a separate application must be completed for each one.

A \$500 application fee must accompany the application(s). \$400 of the application fee will be credited toward your entrance fee payment. The remaining \$100 is a non-refundable application processing fee.

<b>Type of Accommodation Preferred:</b>	
<b><u>Please check which Cottage style you prefer:</u></b>	
<b>A Style Cottage</b> _____	<b>E Style Cottage (Malta style)</b> _____
<b>C Style Cottage</b> _____	<b>F Style Cottage (One car garage)</b> _____ <b>(new)</b>
<b>D Style Cottage</b> _____	<b>G Style Cottage (Two car garage)</b> _____ <b>(new)</b>

I desire residency: Immediately: \_\_\_\_ At a later date \_\_\_\_ (*applicant must contact us in the future*)

Desired date of residency: \_\_\_\_\_

Do you plan to bring a vehicle? Yes \_\_\_\_ No \_\_\_\_ If yes, how many vehicles (*limit of two*)? \_\_\_\_

How did learn of our retirement community? \_\_\_\_\_

\_\_\_\_\_

**I. Demographics Section 1:**

Applicant's Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
Last First Middle Title Suffix

Current Address: \_\_\_\_\_  
Street Town State Zip Code

Telephone No.: \_(\_\_\_\_\_)\_\_\_\_\_ Years at current address: \_\_\_\_\_

Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Widowed \_\_\_\_\_  
Date Date  
Divorced \_\_\_\_\_ Separated \_\_\_\_\_  
Date Date

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security No.: \_\_\_\_\_

**II. Demographics Section 2:**

Spouse's Name: \_\_\_\_\_ Telephone No.: \_(\_\_\_\_\_)\_\_\_\_\_

Spouse's Address: \_\_\_\_\_  
Street Town State Zip Code

Church Name: \_\_\_\_\_ Religious Denomination: \_\_\_\_\_

Pastor's Name: \_\_\_\_\_ Pastor's Telephone No.: \_(\_\_\_\_\_)\_\_\_\_\_

Pastor's Address: \_\_\_\_\_  
Street Town State Zip Code

Birthplace: \_\_\_\_\_ Citizen of: \_\_\_\_\_

Language: \_\_\_\_\_ Maiden Name: \_\_\_\_\_

Veteran? \_\_\_\_\_ Military Branch: \_\_\_\_\_ Years of Service \_\_\_\_\_

Education (Highest): \_\_\_\_\_ Former or Present Occupation: \_\_\_\_\_

List Your Current Hobbies, Talents, or Special Interests: \_\_\_\_\_

Prepaid Burial Reserve:  
Name of Financial Institution: \_\_\_\_\_

Dollar Amount Reserved: \_\_\_\_\_ Is the Agreement irrevocable? Yes \_\_\_\_\_ No \_\_\_\_\_

Funeral Home: \_\_\_\_\_ Telephone No.: \_\_\_\_\_

Funeral Home Address: \_\_\_\_\_  
Street Town State Zip Code

Living Will? Yes \_\_\_\_\_ No \_\_\_\_\_ (Please provide copy upon admission)

**II. Demographics Section 2 (Continued):**

**EMERGENCY CONTACTS:**

**First Contact (First person notified in case of an emergency):**

Name:	_____	Home Phone No.:	_____
Address:	_____	Work Phone No.:	_____
Address:	_____	Cell Phone No.:	_____
		Email address:	_____
Relationship (e.g., Daughter/POA, Guardian):	_____		

**Second Contact (Notified When the First Contact Cannot Be Reached):**

Name:	_____	Home Phone No.:	_____
Address:	_____	Work Phone No.:	_____
Address:	_____	Cell Phone No.:	_____
		Email address:	_____
Relationship (e.g., Daughter/POA, Guardian):	_____		

**Third Contact (Notified When the First & Second Contacts Cannot Be Reached):**

Name:	_____	Home Phone No.:	_____
Address:	_____	Work Phone No.:	_____
Address:	_____	Cell Phone No.:	_____
		Email address:	_____
Relationship (e.g., Daughter/POA, Guardian):	_____		

**OTHER CONTACTS:**

Name:	_____	Home Phone No.:	_____
Address:	_____	Work Phone No.:	_____
Address:	_____	Cell Phone No.:	_____
		Email Address:	_____
Relationship (e.g., Daughter/POA, Guardian):	_____		

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**III. Insurance Information:**

1. Are you enrolled in Medicare? Yes \_\_\_\_\_ No \_\_\_\_\_ Medicare No.: \_\_\_\_\_  
 Part A (*Hospitalization*)? Yes \_\_\_\_\_ No \_\_\_\_\_ Part B? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Are you enrolled in a Medicare HMO? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Name of HMO \_\_\_\_\_ Phone: \_(\_\_\_\_)\_\_\_\_\_  
 HMO Id. No.: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_
3. Do you have Medi-Gap Coverage (*for example, Blue Cross Security 65?*) Yes \_\_\_\_\_ No \_\_\_\_\_  
 Name of Company: \_\_\_\_\_ Insured's ID No.: \_\_\_\_\_  
 Plan Type (circle one): A B C H Group No., if any: \_\_\_\_\_
4. Do you have Medicare Prescription Drug Coverage? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Name of Company: \_\_\_\_\_ Insured's ID No.: \_\_\_\_\_
5. Do you receive Medical Assistance? Yes \_\_\_\_\_ No \_\_\_\_\_ County: \_\_\_\_\_  
 Med. Assistance Recipient No.: \_\_\_\_\_ Expiration Date: \_\_\_\_\_
6. Do you have other Health Insurance Coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ Policy No.: \_\_\_\_\_  
 Name of Company: \_\_\_\_\_ Telephone: \_(\_\_\_\_)\_\_\_\_\_  
 Name of Company: \_\_\_\_\_ Telephone: \_(\_\_\_\_)\_\_\_\_\_

**IV. Financial Information (Please use whole dollar figures only):**

A. Assets**:	Amount	Bank Name (if bank account)	Owners
Market Value of Real Estate*	\$ _____	_____	_____
Checking Accounts	\$ _____	_____	_____
Saving Accounts	\$ _____	_____	_____
Certificates of Deposit	\$ _____	_____	_____
Stocks & Bonds	\$ _____	_____	_____
Mutual Funds	\$ _____	_____	_____
Debts Others Owe to You	\$ _____	_____	_____
Other: _____	\$ _____	_____	_____
Other: _____	\$ _____	_____	_____
Other: _____	\$ _____	_____	_____

\* The market value of Real Estate is based on: \_\_\_\_\_ Appraisal \_\_\_\_\_ Your Estimate

**IV. Financial Information (Continued -Please use whole dollar figures only):**

B. Liabilities**:	Amount	Bank Name (if bank debt)
Mortgages on Real Estate	\$ _____	_____
Outstanding Loans or Notes	\$ _____	_____
Other: _____	\$ _____	_____
Other: _____	\$ _____	_____
Other: _____	\$ _____	_____

<u>C. Monthly Income**:</u>	<u>Amount</u>
Social Security	\$ _____
Pension or Retirement	\$ _____
Annuities	\$ _____
Interest & Dividends	\$ _____
Rental Income	\$ _____
Supplemental Security Income	\$ _____
Other: _____	\$ _____
Other: _____	\$ _____
Other: _____	\$ _____

D. Have any of your assets been transferred to other individuals or organizations within the past five (5) years? Please note that a ‘transfer’ includes all gifts of real estate, vehicles, cash, or other items of value to organizations or individuals during any calendar month. The value of all gifts combined may not exceed \$500 for any month. This would include gifts given to family members for holidays, birthdays, weddings, or any other occasion. Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please indicate what was transferred, who the resources were transferred to, and the value or amount transferred (***please attach sheet***).

\*\*Supporting documentation (such as tax returns and/or bank statements) may be requested.

**V. Medical Information**

A. Hospital and Physicians:

1. Hospital Preference:
  - \_\_\_\_\_ Lewistown Hospital
  - \_\_\_\_\_ J.C. Blair Memorial Hospital
  - \_\_\_\_\_ Mount Nittany Medical Center

2. Ambulance Company: \_\_\_\_\_

3. Physician's Name: \_\_\_\_\_ Telephone: \_(\_\_\_\_)\_\_\_\_\_

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

**B. Personal Health History:**

In order that our Medical Director be fully advised as to our Applicant's Health Status, it is necessary to submit the following information. (At a later date, you will be given a more comprehensive medical report to be filled out by your doctor). The Admission Committee realizes that all applicants have had various illnesses in the course of their lives: however, acceptance of an applicant is not conditioned on perfect health.

1. Estimate, in your own words, the condition of your health. \_\_\_\_\_

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

2. List all chronic diseases (heart, diabetes, kidney, etc.) and the date of onset:

<u>Diseases</u>	<u>Date</u>
_____	_____
_____	_____
_____	_____

3. Specify any physical limitations or deformities (glasses, hearing aid, arthritis, etc.)

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

4. Describe any allergies, including reaction to drugs. \_\_\_\_\_

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

5. List all major surgical operations and dates. \_\_\_\_\_

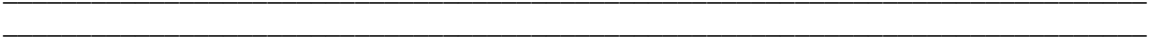
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. List all hospitalizations within the last 10 years. \_\_\_\_\_

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

7. Please describe any special dietary requirements? \_\_\_\_\_

\_\_\_\_\_



Valley View Cottage Application

8. Are you presently under special medical care? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, please describe:

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

9. What medications, including vitamins, are you now taking?

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

10. Are you able to live an independent life style without requiring help of any kind?

Yes \_\_\_\_\_ No \_\_\_\_\_ If no, please describe the kind of help you need:

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

I understand that Valley View Haven 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.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Applicant