



Application for Residency

Applicant #1

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

Residential Living: Allegheny Cottage (A) Susquehanna Cottage (A+) Clarion Cottage (C) Delaware Cottage (D) Lehigh Cottage (E) Juniata Cottage (G)

Personal Care: A-Style Apartment B-Style Apartment C-Style Apartment D-Style Apartment Studio Apartment

Nursing Care: Private Room Semi-Private Room

Memory Care: (All Private Rooms)

Rehab: (All Private Rooms)

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: Allegheny Cottage (A) Susquehanna Cottage (A+) Clarion Cottage (C) Delaware Cottage (D) Lehigh Cottage (E) Juniata Cottage (G)

Personal Care: A-Style Apartment B-Style Apartment C-Style Apartment D-Style Apartment Studio Apartment

Nursing Care: Private Room Semi-Private Room

Memory Care: (All Private Rooms)

Rehab: (All Private Rooms)

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 #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 _____
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

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		

Liabilities	Applicant #1	Applicant #2
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 _____ _____	Home _____ Work _____
		City _____	Mobile _____
		State _____ Zip _____	Email _____
Name	Relationship	Address	Telephone/Contact Info
		Street _____ _____	Home _____ Work _____
		City _____	Mobile _____
		State _____ Zip _____	Email _____
Name	Relationship	Address	Telephone/Contact Info
		Street _____ _____	Home _____ Work _____
		City _____	Mobile _____
		State _____ Zip _____	Email _____

Other Information

How did you hear about Valley View Retirement Community?

- | | | |
|--|--|---|
| <input type="checkbox"/> Church | <input type="checkbox"/> Hospital/Physician Recommendation | <input type="checkbox"/> Internet Search |
| <input type="checkbox"/> Community Event | <input type="checkbox"/> Social Media | <input type="checkbox"/> Live Locally |
| <input type="checkbox"/> Family/Friend is/was a Resident | <input type="checkbox"/> Publications | <input type="checkbox"/> Home Health Agency |
| <input type="checkbox"/> Other (please specify) _____ | | |

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



4702 E. Main St.
 Belleville, PA 17004
 Phone: (717) 935-2105
 Fax: (717) 935-5109
vvrconline.org