

MENNONITE VILLAGE
APPLICATION FOR ADMISSION TO

QUAIL RUN ASSISTED LIVING FACILITY
2525 47TH Ave., SE Albany, OR 97322
Phone: 541-928-1122 Fax: 541-917-1393

All information listed below is confidential and will be used only by Mennonite Village unless written permission is given by the applicant.

APPLICANT # 1: Name: _____
Birth Date: ____/____/____ SS #: _____ Medicare #: _____

APPLICANT # 2 (for spouse): Name: _____
Birth Date: ____/____/____ SS #: _____ Medicare #: _____

Does either applicant presently reside at Mennonite Village? Yes__ No__

Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____

Car License Plate Number, if applicable: _____

LIST TWO CONTACTS, preferably children or siblings:

Name: _____	Name: _____
Relationship: _____	Relationship: _____
Address: _____	Address: _____
City: _____	City: _____
State: _____ ZIP: _____	State: _____ ZIP: _____
Phone Number (Home): _____	Phone Number (Home): _____
(Work): _____	(Work): _____

FINANCIAL INFORMATION

Payment source(s): __ Private __ LTC Ins. __ Medicare __ Medicaid #: _____
Total Monthly Income: \$ _____ Sources: _____

STYLE OF APARTMENT PREFERRED: __ Studio __ One Bedroom

URGENCY OF MOVE: __ Immediate __ In future, how soon? _____

How did you hear about Quail Run Assisted Living? _____

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Name: _____(Complete this page separately for each applicant)

MEDICAL INFORMATION:

Primary Physician: _____

Diagnoses (Major Illnesses): _____

Names of medications presently taking: _____

Medication Assistance Needed (check one):

Self-administration of medications Needs medications to be administered by facility staff and is willing to use bubble-pack system for packaging medications.

Diabetic? Yes___ No___

If yes, taking oral medications (pills) or Insulin injections? _____

Requires special diet? Yes___ No___

If yes, please explain: _____

<u>Activities of Daily Living (ADL's):</u>	<u>Independent</u>	<u>Assist</u>	<u>Dependent</u>
Dressing	_____	_____	_____
Bathing	_____	_____	_____
Toileting	_____	_____	_____
Transferring	_____	_____	_____
Eating	_____	_____	_____

Mobility: Uses Cane___ Walker___ Wheelchair___ Electric cart/Wheelchair___ or No device___ . Requires assistance of another person to move about? Yes___ No___

Psycho-social:

____ History of mental illness or psychotic behavior _____ Short term memory loss
____ Wanders or gets lost frequently _____ Confusion or Disorientation
____ History of hitting, other physical aggression, or agitation
____ None of the above

Do you anticipate any major changes in your health status in the next year?

Yes___ No___ If yes please explain: _____

Applicant's Signature

Date

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COMBINED PERSONAL FINANCIAL STATEMENT

If application is for two persons, is your income combined? Yes No
If yes, continue with statement below. If no, use yellow Personal Financial Statements enclosed.

Names: _____ Date: _____
Applicant #1 Applicant #2

Address: _____ Phone #: _____

ASSETS		LIABILITIES	
Cash (Checking & Savings)		Notes Payable	
Stocks & Securities		Bank Charge Cards	
C.D., Certificates, etc.		Balance Due on Home	
Government Bonds		Real Estate Payable	
Tax assessed home value		Other Liabilities – Describe:	
Appraised home value			
Year of Appraisal			
Other Real Estate		Balance Due on Vehicle	
TOTAL ASSETS		TOTAL LIABILITIES	

INCOME (Monthly)	Applicant #1	Applicant #2	EXPENSES (Approximate Monthly)
Social Security			Auto Expense
Pension/Retirement			Food
Pension/Retirement after death of other applicant			Prescriptions
			Medical Bills
			Medical Insurance
Annuity			Car Insurance
Dividends			Other
Rents			TOTAL EXPENSES
Other			
TOTAL INCOME:			

Do one of both applicants have a Long Term Care Insurance Plan? Yes No Amount of daily benefit? \$ _____
 Life Insurance: Do you have life insurance? App #1 \$ _____ App #2 \$ _____
 Upon death of Applicant #1 will life insurance transfer to Applicant #2? Yes No
 Upon death of Applicant #2 will life insurance transfer to Applicant #1? Yes No

Upon death of Applicant #1 **will all assets transfer** to Applicant #2? Yes No
 Upon death of Applicant #2 **will all assets transfer** to Applicant #1? Yes No
 Upon death will Applicant #1 **pension/retirement transfer** to Applicant #2? Yes No Amount \$ _____
 Upon death will Applicant #2 **pension/retirement transfer** to Applicant #1? Yes No Amount \$ _____

I/We agree not to compromise my/our ability to meet financial obligations by making gifts and transfers inappropriately. I/We verify that the above represents an accurate financial representation. Should the above name(s) become a subsidized resident(s) and any unknown or recent acquired assets occur, this statement creates a lien against such assets in favor of the provider.

Applicant #1 Signature

Applicant #2 Signature

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INDIVIDUAL PERSONAL FINANCIAL STATEMENT

Name: _____ Date: _____

Address: _____ Phone #: _____

ASSETS		LIABILITIES	
Cash (Checking & Savings)		Notes Payable	
Stocks & Securities		Bank Charge Cards	
C.D., Certificates, etc.		Balance Due on Home	
Government Bonds		Real Estate Payable	
Tax assessed Home Value		Other Liabilities – Describe:	
Appraised Home Value			
Year of Appraisal			
Other Real Estate		Balance Due on Vehicle	
TOTAL ASSETS		TOTAL LIABILITIES	

INCOME (Monthly)		EXPENSES (Approximate Monthly)	
Social Security		Auto Expense	
Pension/Retirement		Food	
Pension/Retirement after death of other applicant		Prescriptions	
		Medical Bills	
		Medical Insurance	
Annuity		Car Insurance	
Dividends		Other	
Rents		TOTAL EXPENSES	
Other			
TOTAL INCOME:			

Life Insurance: Do you have a Life Insurance plan? Yes No
 Upon death of a spouse, will life insurance transfer to you? Yes No
 Do you have Long Term Care Insurance plan? Yes No. (If you qualify for benefits, what is the daily rate of pay? \$_____)

I agree not to compromise my ability to meet financial obligations by making gifts and transfers inappropriately. I/We verify that the above represents an accurate financial representation. Should the above name(s) become a subsidized resident(s) and any unknown or recent acquired assets occur, this statement creates a lien against such assets in favor of the provider.

_____ Applicant Signature

_____ Date