MENNONITE VILLAGE

Care Area Application for Admission

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

At the time of application, assets, liabilities, income and expenses will be reviewed. Mennonite Village requires proof of financial statement criteria prior to admission, per corporate policy.

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__

Applicant(s) Address: _____ Phone Number: _____
City: _____ State: _____ Zip Code: _____

Car License Plate Number, if applicable: _____

LIST TWO CONTACTS, preferably Power of Attorney, children or siblings:

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

FINANCIAL INFORMATION:
Payment source(s): __ Private __ LTC Ins. __ Medicaid: #_____

Total Monthly Income: $ _____ Sources: _____

URGENCY OF MOVE: __Immediate __In future, how soon? _____

CARE AREA : __ Quail Run Assisted Living (__ Studio __One Bedroom)
__ Mary's Place Adult Foster Home
__ Lydia's House Memory Care

How did you hear about us? _____

Mennonite Village checks the National and/or State of Oregon sexual offender websites to determine if the applicant is registered as a sexual offender or as a sexually violent predator.

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

MEDICAL INFORMATION:
Primary Physician: _____
Physician Phone:_____ Fax:_____
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 (Quail Run utilizes a 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: _____

Activities of Daily Living (ADL's):	Independent	Assist	Dependent
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 Individual Personal Financial Statements enclosed.

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

ASSETS			**LIABILITIES**	
Cash (Checking & Savings)			Current debt	
Securities (stocks, bonds, mutual funds)			Notes payable:	
C.D., Certificates, etc.			Taxes payable (property, personal)	
Annuities			Real Estate (mortgage balance)	
Real estate (market value)			Other loans (vehicle, RV, etc.)	
Auto(s)			Other Liabilities – Describe:	
Other (Burial, Trusts, Family support, Life Lease Refund)				
TOTAL ASSETS			TOTAL LIABILITIES	

INCOME (Monthly)	**Applicant #1**	**Applicant #2**		**EXPENSES (Approximate Monthly)**	
Social Security				Auto (insurance, fuel)	
Pension/Retirement				Food and household	
Pension/Retirement (after death of other applicant)				Health insurance	
				Health, dental, prescription	
Annuity				Mortgage	
Dividends				Other	
Rents				TOTAL EXPENSES	
Other					
TOTAL INCOME					

Do one or 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)			Current debt	
Securities (stocks, bonds, mutual funds)			Notes payable:	
C.D., Certificates, etc.			Taxes payable (property, personal)	
Annuities			Real Estate (mortgage balance)	
Real estate (market value)			Other loans (vehicle, RV, etc.)	
Auto(s)			Other Liabilities – Describe:	
Other (Burial, Trusts, Family support, Life Lease Refund)				
TOTAL ASSETS			TOTAL LIABILITIES	

INCOME (Monthly)			**EXPENSES (Approximate Monthly)**	
Social Security			Auto expenses (insurance, fuel)	
Pension/Retirement			Food and household	
Annuity			Health insurance	
Dividends			Health, dental, prescription	
Rents			Mortgage	
Other			Other	
TOTAL INCOME:			TOTAL EXPENSES	

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