

Worthington Christian Village Application for Residency

(Each applicant is asked to complete this form individually and completely)

Name _____
(First) (Middle) (Last)

Address _____ Phone _____
(Street) (City) (State) (Zip Code)

How long have you lived at your present address? _____ With whom do you now reside? _____

Age _____ Date of Birth _____ Place of Birth _____
(MM/DD/Year) (City, State)

Are you a citizen of the United States? Yes No If not, what country? _____

Marital Status: (circle one) *Married Single Widowed Divorced* If widowed, spouse's first name? _____

Church Membership or preference? _____ Address _____

What has been your occupation? _____

List relatives or preferred persons for contact in case of an emergency in the order you would like them to be contacted:

NAME	FULL ADDRESS	RELATIONSHIP/PHONE
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____

Do you have a living will? Yes No Is your will current? Yes No

Do you have a Durable Power of Attorney for Health Care? Yes No If so, who _____

Do you have Power of Attorney (*Financial*) Yes No if so, who _____

Please turn in copies of your living will and power of attorney paperwork with this application

Do you consider your overall health for your age to be: (circle one) *Excellent Good Fair Poor*

Do you require a special diet? Yes No Do you smoke? Yes No Do you drink alcoholic beverages? Yes No

Condition of your Eyesight: *Excellent Good Fair Poor* Condition of your hearing: *Excellent Good Fair Poor*

If handicapped in any way, please explain _____

Your primary physician's name & address _____

List your Hospitalization, Health Insurance Policy, and/or Medicare Gap Policy:

Are you enrolled in the Medicare programs of :(circle one or both) *Hospital Insurance (Part A) Doctor's Services (Part B)*

If not, why? _____ Do you plan to continue these policies? Yes No

Your Social Security # _____ Your Medicare # _____

Long Term Care Insurance Company _____ Policy # _____

For what residency option are you applying?(please circle one): *Independent Cottage Independent Apartment Assisted Living*

Cottage: *A B C* Apartment: *Studio A B C D F G H I K* Assisted Living: *Private Semi-Private One Bedroom*

Approximate date residency is desired: _____

FINANCIAL STATEMENT

Please fill out this statement completely. When necessary, average the amount to obtain the monthly figure. All information listed here and elsewhere in this application will be treated in a confidential manner by Worthington Christian Village.

NOTE: If a couple, list income, assets and liabilities separately. If common to both, complete only one financial statement.

REGULAR INCOME

Social Security	\$		per month
Pension	\$		per month
Dividends	\$		per month
Interest	\$		per month
Rental Income	\$		per month
Other Income Source: _____	\$		per month
TOTAL REGULAR MONTHLY INCOME	\$		

REGULAR EXPENSES

Medicine or Prescriptions	\$		per month
Taxes : Income or Property	\$		per month
Payments : Notes or Mortgages	\$		per month
Contributions or Gifts	\$		per month
Insurance Premiums	\$		per month
Other living expenses	\$		per month
TOTAL REGULAR EXPENSES	\$		

CAPITAL ASSETS

Cash (savings & checking)	\$	
Stocks & Bonds	\$	
Home or Other Real Estate	\$	
Life Insurance	\$	
Other Source: _____	\$	
TOTAL ASSETS	\$	

LIABILITIES

Mortgage	\$	
Notes Payable	\$	
Personal Debt	\$	
Other Liabilities	\$	
TOTAL LIABILITIES	\$	

Do you plan to bring your car? Yes No

Have you transferred any money, property, or other assets, real or personal, within the past 5 years? Yes No

If yes, please state the circumstances, the person to whom they were transferred, and the value of assets transferred:

Description	Transferred to	Value

Where the figures show an income inadequate to meet monthly costs of service, some member of the family must assume the responsibility for payment, and complete the enclosed form listing their monthly income and assets.

*I will be responsible for providing the funds necessary for the care of: _____
(name of applicant)*

Signed _____ Relationship _____

Address _____

Employed By: _____ How Long? _____

Financial Reference _____

I do hereby make application for residency in Worthington Christian Village. I am in full sympathy with the ideals, rules and regulations of the Village and agree to wholeheartedly cooperate with the management according to the statements as set forth in the Resident Agreement. I make this application with the understanding the financial and health statements contained herein may be investigated by action of the Admissions Committee, should they deem such action necessary.

Applicant's Signature _____ Date _____

Notary
State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____ 20 ____.

My commission expires: _____ Notary Public _____

Physician's Confidential Report

To be filled in and returned directly to

Worthington Christian Village, 165 Highbluffs Boulevard, Columbus, Ohio 43235 Fax # 614-842-9541

Name of Applicant _____ Age _____

Address _____ City _____ State _____

Height _____ Weight _____ Blood Pressure _____ Pulses _____

How long have you known your patient? _____

Current illness or disability _____

Prognosis of illness or disability _____

Prosthesis now used by patient (including dentures, glasses, hearing aids, trusses, braes, artificial limbs, walking aides, wheel chair, etc.) _____

Past Medical History

Diagnosis _____

Operations with dates _____

Major injuries with dates _____

Present medications (including psychotropic meds) _____

Drug allergies _____

Systems Review

EENT _____

Neuropsychiatric _____

Cardiorespiratory _____

Gastrointestinal _____

Genitourinary – Incontinence _____

Is person incontinent of bladder? Yes No

If yes, can person manage it on their own? Yes No

Is person incontinent of bowel? Yes No

If yes, can person manage it on their own? Yes No

If no, please explain _____

Musculoskeletal _____

Endocrine _____

Physical Exam

Eyes _____

Ears _____

Nose _____

Mouth and throat _____

Neck (thyroid and caotid bruit) _____

Chest including breasts _____

Heart and lungs _____

Abdomen _____

Genitourinary including rectal exam _____

Skin _____

Extremities _____

Neurological _____

Lymphatic System _____

Laboratory

CBC, U/A _____

Chemistry Profile _____

Date of most recent Pneumonia shot _____

Date of most recent Flu shot _____

Any other indicated lab work _____

Mental Status

Mini-Mental Exam (MMSE) *score required for admission* _____

General mental condition and alertness _____

Impressions and Recommended Treatment

Does this person need assistance with activities of daily living? If yes, please explain. Yes No

Is the person able to do the following:

	Yes	No	If no, please explain
Light housework			
Walk back and forth to dining room			
Take own bath			
Dress self without assistance			
Take medications without assistance			
Perform transfers safely independently			
Make appropriate food selections and feed self independently			

Is this person receiving any in-home health services (medical or non-medical)? If yes, please explain. Yes No

Based on all of the proceeding information, what level of care would you recommend for this person?

Independent Living Assisted Living Nursing Care

Printed Name of Examining Physician _____

Signature of Examining Physician _____

Date of Examination _____ **Phone** _____ **Fax** _____

Address: Street _____ **City** _____ **State** _____ **Zip Code** _____