WORTHINGTON
CHRISTIAN VILLAGE

APPLICATION FOR RESIDENCY

165 Highbluffs Blvd., Columbus, Ohio 43235 (614) 846-6076 www.wcv.org

EQUAL HOUSING OPPORTUNITY

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)
Email _____

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:

1. Name: _____ **Relationship to Applicant**: _____

Address: _____City_____State_____Zip_____

Phone: _____Email:_____

2. Name: _____ **Relationship to Applicant**: _____

Address: _____City_____State_____Zip_____

Phone: _____Email:_____

3. Name: _____ **Relationship to Applicant**: _____

Address: _____City_____State_____Zip_____

Phone: _____Email:_____

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 below information.

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_____

Dates of COVID Vaccine_____

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**_____