



## APPLICATION FOR RESIDENCY

165 Highbluffs Blvd., Columbus, Ohio 43235 (614) 846-6076 [www.wcv.org](http://www.wcv.org)



# 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 <b>Source:</b> _____	\$		per month
<b>TOTAL REGULAR MONTHLY INCOME</b>	<b>\$</b>		

## 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
<b>TOTAL REGULAR EXPENSES</b>	<b>\$</b>		

## CAPITAL ASSETS

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

## LIABILITIES

Mortgage	\$	
Notes Payable	\$	
Personal Debt	\$	
Other Liabilities	\$	
<b>TOTAL LIABILITIES</b>	<b>\$</b>	

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 \_\_\_\_\_

Asthma, hay fever or drug sensitivity \_\_\_\_\_

Present medications (including psychotropic meds) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## 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 \_\_\_\_\_

Mantoux test (date given/date read) *required for admission* \_\_\_\_\_

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
Do light housework			
Walk back and forth to dining room			
Take own bath			
Dress self without assistance			
Take medication without assistance			
Perform transfers safely independently			If no, is person a one or two person transfer?

**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** \_\_\_\_\_

**Address: Street** \_\_\_\_\_ **City** \_\_\_\_\_ **State** \_\_\_\_\_ **Zip Code** \_\_\_\_\_

**Please attach a recent H&P and current medication list along with this form.**