THE SYLVESTERY

Application for Move-In

Return to The Sylvestery with $100 non-refundable application fee payable to Vinson Hall Corporation

Name: _____
(Last) *(First)* *(MI)*

Address: _____

_____

Email: _____

Gender: *(please circle)*
Male Female

Telephone Number(s):
H ( ) _____
W ( ) _____
C ( ) _____

Age	Date of Birth:	Birth Place:	Citizenship:

Marital Status:
☐ Married
☐ Widowed
☐ Divorced
☐ Separated
☐ Single

Social Security Number:

Medicare Number:

Military Affiliation:
_____
(Name) *(Relationship)*

Branch of Service: _____

Rank:

Religious Affiliation:

Name of Pastor/Leader:

Telephone Number:
( ) _____

Additional Insurance Information

Other Insurance: _____
(Name)
Policy Number: _____

Other Insurance: _____
(Name)
Policy Number: _____

Name of Spouse:

Telephone Number(s): ( ) _____
( ) _____

Billing Information

Bill To:

Name: _____

Address: _____

_____

Email: _____

POA
Relationship: _____ Yes / No

Phone: Home: ( ) _____

Work: ( ) _____

Cell: ( ) _____

Application for Move-in Cont. | **Name:**

Notify in Case of Emergency (Please List Three)

(#1) Name: _____
Address: _____
_____
Email: _____

POA
Relationship: _____ Yes / No
Phone: Home: ( ) _____
Work: ( ) _____
Cell: ( ) _____

(#2) Name: _____
Address: _____
_____
Email: _____

POA
Relationship: _____ Yes / No
Phone: Home: ( ) _____
Work: ( ) _____
Cell: ( ) _____

(#3) Name: _____
Address: _____
_____
Email: _____

POA
Relationship: _____ Yes / No
Phone: Home: ( ) _____
Work: ( ) _____
Cell: ( ) _____

Possible Move-in Date & Length of Stay

Anticipated Length of Stay: ☐ Less than 30 days ☐ 30-180 Days ☐ Long Term

Date of Requested Move-in:

Health Information

Attending Physician

Name: _____
Address: _____
_____
Telephone Number: ( ) _____

Consulting Physician

Name: _____
Address: _____
_____
Telephone Number: ( ) _____

Please list all diagnoses:

Please list all known allergies:

Application for Move-in Cont.	**Name:**

Hospital Preference:	Funeral Home Preference:

Name of Nursing Home in which you have resided: _____

Address: _____ Telephone No.( ) _____

_____

Dates of Stay: _____ Administrator: _____

Functional Ability

Directions: Please describe the assistance needed in the following areas.

Walking:

Bathing:

Communication: *(sight, hearing & speech)*

Dressing:

Eating:

Toileting:

Special Diets:

Skin Condition:

Additional Comments:

Social Information

Special Interests/Hobbies	**Past Occupation/Career**
_____	_____
_____	_____
_____	_____

FINANCIAL PROFILE

Name:	**Phone: ( )**	
Address: _____ _____	**Years at Present Address:**	***Please Circle:*** **Rent Own**

Financial Profile *PLEASE PROVIDE SUPPORTING DOCUMENTATION

Monthly Expenses		***Monthly Income**	
Mortgage	$	Social Security	$
Rent	$	Pensions	$
Utilities	$	Investments	$
Medical	$	Interest	$
Living	$	Other	$
Other	$		
TOTAL		**TOTAL**	

***Assets**		**Liabilities**	
Cash	$	Mortgage	$
Stocks/Funds	$	Second Trust	$
Money Markets	$	Loans	$
CDs/Bonds	$	Credit Cards	$
Real Estate	$	Other	$
Life Insurance	$	**TOTAL**	
Burial Insurance	$	Do you have Long-term Care Insurance? ☐ Yes ☐ No	
Other	$	Please provide copy of the Policy Declaration Page	
TOTAL		$_____ per day for _____ years	

Agreement & Signatures

Name of Responsible Party:	Responsible Party has the Following: ☐ Power of Attorney ☐ Guardianship ☐ Conservator

I hereby certify that the information I have given is true and correct. I understand that the omission or falsification of any requested information may be grounds for discharge.

Responsible Party:	Signature	Date
Relationship to Resident		
Power of Attorney:	Signature	Date