Mennonite Village

Application for Care Area Admission

APPLICANT #1:	Name:	Birth Date:
APPLICANT #2: (Spouse)	Name:	Birth Date:

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:_____	State:_____
Phone Number:_____	Phone Number:_____
Other:_____	Other:_____

FINANCIAL INFORMATION:

Payment source(s): Private Long Term Care Insurance Medicaid #

Total Monthly Income: $	Sources:

URGENCY OF MOVE: Immediate Future, time frame?

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?

MEDICAL INFORMATION (For Applicant #1)**:**

Primary Physician:	Physician Phone:
	Physician Fax:

Do you have a history of any of the following?

Diabetes	Yes	No	Medication: _____
Cardiac related	Yes	No	Medication: _____
CHF	Yes	No	Medication: _____
Blood Pressure	Yes	No	Medication: _____
Anxiety	Yes	No	Medication: _____
Depression	Yes	No	Medication: _____
PTSD	Yes	No	Medication: _____
COPD	Yes	No	Medication: _____
Memory Loss	Yes	No	Medication: _____
Skin Breakdown	Yes	No	Medication: _____

History of Wandering? Yes No - If yes, please explain:

Medication Assistance Needed (check one):
Self-administration of medications Needs medications to be administered by facility staff
(Our campus utilizes a bubble-pack system for packaging medications.)

Requires special diet? (Texture modified, puree, gluten intolerance etc.): 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 No device
Requires assistance of another person to move about? Yes No
History of falls in the past 6 months? Yes No
If yes, please explain:

MEDICAL INFORMATION (If applicable Applicant #2):

Primary Physician:	Physician Phone:
	Physician Fax:

Do you have a history of any of the following?

Diabetes	Yes	No	Medication: _____
Cardiac related	Yes	No	Medication: _____
CHF	Yes	No	Medication: _____
Blood Pressure	Yes	No	Medication: _____
Anxiety	Yes	No	Medication: _____
Depression	Yes	No	Medication: _____
PTSD	Yes	No	Medication: _____
COPD	Yes	No	Medication: _____
Memory Loss	Yes	No	Medication: _____
Skin Breakdown	Yes	No	Medication: _____

History of Wandering? Yes No - If yes, please explain:

Medication Assistance Needed (check one):
Self-administration of medications Needs medications to be administered by facility staff
(Our campus utilizes a bubble-pack system for packaging medications.)

Requires special diet? (Texture modified, puree, gluten intolerance etc.): 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 No device

❑ Requires assistance of another person to move about? Yes No

History of falls in the past 6 months? Yes No

If yes, please explain:

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 Statement.

Names:	Applicant 1:	Applicant 2:	Date:

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 applicants have a Long Term Care Insurance Plan? Yes No Daily benefit amount? $_____

Life Insurance: Do you have life insurance? App #1_____ $_____ App #2_____ $_____

Upon death of App #1 will life insurance transfer to App #2? Yes No

Upon death of App #2 will life insurance transfer to App #1? Yes No

Upon death of App#1 will all assets transfer to App #2? Yes No

Upon death of App #2 will all assets transfer to App #1? Yes No

Upon death will App #1 pension/retirement transfer to App #2? Yes No Amount $_____

Upon death will App #2 pension/retirement transfer to App #1? Yes No Amount $_____

INDIVIDUAL PERSONAL FINANCIAL STATEMENT

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.)	
Autos		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 – Describe:		Other – Describe:	
Total Income		**Total Expenses**	

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 LTC benefits, what is the daily benefit amount? $_____

SIGNATURE

- 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.
- Mennonite Village is subject to the federal Fair Housing Act, which prohibits any preference, limitation, or discrimination because of race, color, religion, sex, handicap,familial status, or national origin, or intention to make such a preference, limitation, or discrimination.
- 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.
- All information listed 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.
- Quail Run & Lydia's House do have Medicaid contracts, however the facility does not determine who qualifies for Medicaid eligibility.

Applicant Signature:	Date:
Applicant #2 Signature (If applicable):	Date: