HEALTHCARE & COMMUNITY LIVING

Date:_____

# RESIDENCY APPLICATION

**Please indicate the area for which you are applying:**

- ☐ Independent living (Wesley Park)
- ☐ Assisted Care (Palmer House)
- ☐ Skilled Nursing Care (Maplewood Center)
- ☐ Ventilator Care Center (skilled nursing)

VMP Healthcare & Community Living is a Wisconsin nonprofit corporation, own and operate Independent Living, Community-Based Residential Facility, RCAC and Skilled Nursing accommodations. They are members of the family of senior services collectively known as VMP.

*All information given by applicant(s) is held in strict confidence.*
*Please complete a separate application for each individual seeking entrance.*

## I. PERSONAL INFORMATION

Name_____
Last First Middle

Main Address_____City_____

County_____State_____Zip_____Telephone( )_____
Area Code

Date of Birth_____Age_____ Sex_____

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

Occupation (previous) _____ Place of employment_____

Religion_____ Pastor_____ Pastor's Phone_____

Name of your church _____ Address _____

### Health Insurance Information

Part A_____

Social Security #_____Medicare #_____ Effec. Date-Part B_____

Medicaid #(Title XIX)_____Railroad Retirement #_____

Veterans Insurance #_____

### Supplemental Insurance Information:

Name of Insurance Company_____Group# _____ Policy#_____

Address_____Phone_____

Additional Insurance _____Group#_____Policy#_____

Address_____Phone_____

## II. CONTACT INFORMATION

### Financial Information (For Billing Purposes Only)

Financial Responsible Party _____ Relationship _____

Address _____ City _____ State _____ Zip_____

Home Phone _____Work Phone_____E-mail_____

Personal Responsible Party _____ Relationship _____

Address _____ City _____ State _____ Zip_____

Home Phone _____Work Phone_____E-mail_____

Does any member of your family, or another person/institution have any of the following:

☐ Power of Attorney ☐ Guardianship ☐ Conservatorship ☐ Trustee

Name _____ Relationship _____

Address _____ Phone_____

Name _____ Relationship _____

Address _____ Phone_____

Please provide VMP Healthcare & Community Living with a copy of the applicable document.

### Emergency Contact (In the order you wish them to be notified)

Name _____ Relationship _____

Address _____ City_____ State _____ Zip_____

Home Phone _____Work Phone_____E-mail_____

Name _____ Relationship _____

Address _____ City_____ State _____ Zip_____

Home Phone _____Work Phone_____E-mail_____

Name _____ Relationship _____

Address _____ City_____ State _____ Zip_____

Home Phone _____Work Phone_____E-mail_____

## III. BIRTH INFORMATION

Birthplace_____ County of_____ State_____ Country_____

Nationality_____ Citizen of _____

Name of Spouse (if appropriate) _____ Spouse's Maiden Name_____

Father's Name _____ Father's Birthplace _____

Mother's Maiden Name _____ Mother's Birthplace _____

## IV. MEDICAL INFORMATION

Primary Physician _____ Office Phone _____

Address _____ Home Phone _____

Alternate Physician _____ Office Phone _____

Address _____ Home Phone _____

Dentist _____ Office Phone _____

Address _____

Podiatrist _____ Office Phone _____

Address _____

### Other Physicians or Specialists who care for you:

Name _____ Address _____

Office Phone _____ Specialty _____

Name _____ Address _____

Office Phone _____ Specialty _____

Name _____ Address _____

Office Phone _____ Specialty _____

## V. HOSPITALIZATION

Any hospitalization in past 60 days? ☐ Yes ☐ No

If yes, where? _____ Days hospitalized _____

Any admission to a nursing home in past 60 days? ☐ Yes ☐ No

If yes, where? _____ Address _____

Date of admission _____ Date of discharge _____

Any assistance from a home health agency in the past year? ☐ Yes ☐ No

If yes, what is agency's name? _____

Dates of service _____

## VI. OTHER

Do you have a Durable Power of Attorney for health care decisions? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No If yes, please provide us with a copy of these documents.

Have you made any organ donor arrangements? ☐ Yes ☐ No

With whom? _____ Organ(s) _____

Do you have a will? ☐ Yes ☐ No If yes, with whom is it deposited? _____

**Funeral Arrangements:**

Name of Funeral Home_____

Address_____ Phone _____

War Veteran ☐ Yes ☐ No War Service dates from _____ to _____

Do you have a Marital Property Agreement? ☐ Yes ☐ No If yes, please provide us with a copy.

Hobbies or Interests _____

_____

Memberships in clubs or organizations _____

_____

## VII. TYPE OF ROOM DESIRED

VMP Healthcare & Community Living reserves the right to request payment for charges you are unable to pay or do not pay, or are not paid on your behalf by a third party (not covered by Medicare, Medicaid, or supplemental insurance) from person(s) stated as having a Power of Attorney or other control over your assets. Personal liability of stated person(s) shall be limited to your assets placed by you in the possession of or under the control of stated person(s). "Charges" are those stated amounts which may be made by VMP and their agents in providing you care and residency as defined in the Admission Agreement.

## VIII. LEGAL SIGNATURE

**I certify that the above information is true and accurate to the best of my knowledge.**

_____
Applicant Date

_____
*Spouse (if appropriate)* Date

_____
Other Relationship Date

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(Office Use Only)

Authorized_____ Date:_____

Comments: Please attach separate sheet

# Unit Selection

**Independent Living**
- ☐ Studio
- ☐ 1 Person ☐ 2 People
- ☐ 1 Bedroom
- ☐ 2 Bedroom
- ☐ 2 Bedroom / 2 Bath

**Assisted Living**
- ☐ Standard
- ☐ Kitchenette
- ☐ Large ☐ 1 Person ☐ 2 People
- ☐ Apartment ☐ 1 Person ☐ 2 People

**Skilled Nursing**
- ☐ Private
- ☐ Semi - Private

**Ventilator Care Center**
- ☐ Private