VALLEY VIEW
Retirement Community

COTTAGE ADMISSION APPLICATION

Valley View Retirement Community
4702 East Main Street
Belleville, PA 17004
PH: (717) 935-2105 • Fax: (717) 935-5109

APPLICATION FOR A COTTAGE AT :

Valley View Retirement Community Belleville, PA

The information asked for in this application is needed to evaluate the applicant's request for residency. All information will be considered by the Admissions Committee and will be held in strict confidence. The acceptance of this application does **not** bind either party to admission. Failure to complete the application in its entirety could result in denial of consideration for admission. When two individuals apply together, a separate application must be completed for each one.

A $500 application fee must accompany the application(s). $400 of the application fee will be credited toward your Entrance Fee amount when you sign your Cottage Agreement. The remaining $100 is a non-refundable application-processing fee. If you do not take a cottage any time after your application approval, Valley View retains the full $500 application fee.

Type of Accommodation Preferred:	
Please check which Cottage style you prefer:	
A Style Cottage _____	**E Style Cottage (One care garage)** _____
C Style Cottage _____	**G Style Cottage (Two car garage)** _____
D Style Cottage _____	

I desire residency: Immediately: ____ At a later date ____ (*applicant must contact us in the future*)

Desired date of residency: _____

Do you plan to bring a vehicle? Yes _____ No _____ If yes, how many vehicles (*limit of two*)? _____

How did learn of our retirement community? _____

_____

I. Demographics Section 1:

Applicant's Name: _____ _____ _____ Gender: _____
Last First Middle Title Suffix

Current Address: _____
Street Town State Zip Code

Telephone No.: _(_____)_____ Years at current address: _____

Marital Status: Single _____ Married _____ Widowed _____
Date Date

Divorced _____ Separated _____
Date Date

Date of Birth: _____ Age: _____ Social Security. No.: _____

II. Demographics Section 2:

Spouse's Name: _____ Telephone No.: _(_____)_____

Spouse's Address: _____
Street Town State Zip Code

Church Name: _____ Religious Denomination: _____

Pastor's Name: _____ Pastor's Telephone No.: _(_____)_____

Pastor's Address: _____
Street Town State Zip Code

Birthplace: _____ Citizen of: _____

Language: _____ Maiden Name: _____

Veteran? _____ Military Branch: _____ Years of Service _____

Education (Highest): _____ Former or Present Occupation: _____

List Your Current Hobbies, Talents, or Special Interests: _____

_____

Prepaid Burial Reserve:

Name of Financial Institution: _____

Dollar Amount Reserved: _____ Is the Agreement irrevocable? Yes ____ No ____

Funeral Home: _____ Telephone No.: _____

Funeral Home Address:

_____
Street Town State Zip Code

Living Will? Yes ____ No ____ *(Please provide copy upon admission)*

II. Demographics Section 2 (Continued):

EMERGENCY CONTACTS:

First Contact (First person notified in case of an emergency):

Name: _____ Home Phone No.: _____

Address: _____ Work Phone No.: _____

Address: _____ Cell Phone No.: _____

Email address: _____

Relationship (e.g., Daughter/POA, Guardian): _____

Second Contact (Notified When the First Contact Cannot Be Reached):

Name: _____ Home Phone No.: _____

Address: _____ Work Phone No.: _____

Address: _____ Cell Phone No.: _____

Email address: _____

Relationship (e.g., Daughter/POA, Guardian): _____

Third Contact (Notified When the First & Second Contacts Cannot Be Reached):

Name: _____ Home Phone No.: _____

Address: _____ Work Phone No.: _____

Address: _____ Cell Phone No.: _____

Email address: _____

Relationship (e.g., Daughter/POA, Guardian): _____

OTHER CONTACTS:

Name: _____ Home Phone No.: _____

Address: _____ Work Phone No.: _____

Address: _____ Cell Phone No.: _____

Email Address: _____

Relationship (e.g., Daughter/POA, Guardian): _____

III. Insurance Information:

1. Are you enrolled in Medicare? Yes _____ No _____ Medicare No.: _____
   Part A *(Hospitalization)*? Yes _____ No _____ Part B? Yes _____ No _____
2. Are you enrolled in a Medicare HMO? Yes _____ No _____
   Name of HMO _____ Phone: _(_____)_____
   HMO Id. No.: _____ Primary Care Physician: _____
3. Do you have Medi-Gap Coverage *(for example, Blue Cross Security 65?)* Yes _____ No _____
   Name of Company: _____ Insured's ID No.: _____
   Plan Type (circle one): A B C H Group No., if any: _____
4. Do you have Medicare Prescription Drug Coverage? Yes _____ No _____
   Name of Company: _____ Insured's ID No.: _____
5. Do you receive Medical Assistance? Yes ____ No ____ County: _____
   Med. Assistance Recipient No.: _____ Expiration Date: _____
6. Do you have other Health Insurance Coverage? Yes _____ No _____ Policy No.:_____
   Name of Company: _____ Telephone: _(_____)_____
7. Do you have Long Term Care Insurance? Yes _____ No _____ Policy No.:_____
   Name of Company: _____ Telephone: _(_____)_____

IV. Financial Information (Please use whole dollar figures only):

A. Assets**:	Amount	Bank Name (*if bank account*)	Owners
Market Value of Real Estate*	$ _____	_____	
Checking Accounts	$ _____	_____	
Saving Accounts	$ _____	_____	
Certificates of Deposit	$ _____	_____	
Stocks & Bonds	$ _____	_____	
Mutual Funds	$ _____	_____	
Debts Others Owe to You	$ _____	_____	
Other: _____	$ _____	_____	
Other: _____	$ _____	_____	
Other: _____	$ _____	_____	

* The market value of Real Estate is based on:____ Appraisal ____ Your Estimate

IV. Financial Information (Continued -Please use whole dollar figures only):

B. Liabilities**:	Amount	Bank Name (*if bank debt*)
Mortgages on Real Estate	$ _____	_____
Outstanding Loans or Notes	$ _____	_____
Other: _____	$ _____	_____
Other: _____	$ _____	_____
Other: _____	$ _____	_____

C. Monthly Income**:	Amount
Social Security	$ _____
Pension or Retirement	$ _____
Annuities	$ _____
Interest & Dividends	$ _____
Rental Income	$ _____
Supplemental Security Income	$ _____
Other: _____	$ _____
Other: _____	$ _____
Other: _____	$ _____

D. Have any of your assets been transferred to other individuals or organizations within the past five (5) years? Please note that a 'transfer' includes all gifts of real estate, vehicles, cash, or other items of value to organizations or individuals during any calendar month. The value of all gifts combined may not exceed $500 for any month. This would include gifts given to family members for holidays, birthdays, weddings, or any other occasion. Yes _____ No _____ If yes, please indicate what was transferred, who the resources were transferred to, and the value or amount transferred ***(please attach sheet)***.

***Supporting documentation (such as tax returns and/or bank statements) may be requested.*

V. Medical Information

A. Hospital and Physicians:

1. Hospital Preference:
   - _____ Lewistown Hospital
   - _____ J.C. Blair Memorial Hospital
   - _____ Mount Nittany Medical Center

2. Ambulance Company: _____

3. Physician's Name: _____ Telephone: _(_____)_____

Address: _____

B. Personal Health History:

In order that our Medical Director be fully advised as to our Applicant's Health Status, it is necessary to submit the following information. (At a later date, you will be given a more comprehensive medical report to be filled out by your doctor). The Admission Committee realizes that all applicants have had various illnesses in the course of their lives: however, acceptance of an applicant is not conditioned on perfect health.

1. Estimate, in your own words, the condition of your health._____
_____
_____
_____

2. List all chronic diseases (heart, diabetes, kidney, etc.) and the date of onset:

Diseases	Date
_____	_____
_____	_____
_____	_____

3. Specify any physical limitations or deformities (glasses, hearing aid, arthritis, etc.)
_____
_____
_____

4. Describe any allergies, including reaction to drugs. _____
_____
_____
_____

5. List all major surgical operations and dates. _____
_____
_____
_____

6. List all hospitalizations within the last 10 years. _____
_____
_____
_____

7. Please describe any special dietary requirements? _____
_____
_____
_____

8. Are you presently under special medical care? Yes _____ No _____ If yes, please describe:
   _____
   _____
   _____

9. What medications, including vitamins, are you now taking?
   _____
   _____
   _____

10. Are you able to live an independent life style without requiring help of any kind?

    Yes _____ No _____ If no, please describe the kind of help you need:
    _____
    _____
    _____

I understand that Valley View Haven retains the right to accept or reject any application consistent with the law. I certify that all of the information submitted on this application is true and correct, and I understand the submission of false information may constitute grounds for rejection of this application or my discharge after admission.

_____ _____

Date Signature of Applicant