



1 Applicant Information

NAME OF APPLICANT

PHONE

ADDRESS

CITY

STATE

ZIP

2 Application Type

For which section of the Villa is the applicant applying?

Retirement Center

Special Care Unit

3 Current Living Situation

Is the applicant currently in a retirement center or nursing home?

Yes

No

IF YES, NAME OF FACILITY

ADDRESS

CITY

STATE

ZIP

May we call for information?

Yes

No

IF YES, CONTACT PERSON

PHONE

4 Demographics

AGE

BIRTHDAY

BIRTHPLACE

SEX

RELIGION

NATIONALITY

MARITAL STATUS

IF WIDOWED, DATE OF SPOUSE'S DEATH



5 Legal Representative

Person or agency with legal authority for the applicant.

Is there a legal representative? Yes No If yes, check the category below:

Conservator Guardian Power of Attorney Designated Resp. Other

REPRESENTATIVE NAME

[Text input field for Representative Name]

ADDRESS CITY STATE ZIP

[Text input fields for Address, City, State, and ZIP]

RELATIONSHIP TO APPLICANT EMAIL

[Text input fields for Relationship to Applicant and Email]

6 Emergency Contacts

List three persons; only one will be contacted, in priority order.

A Contact A

NAME RELATIONSHIP TO APPLICANT

[Text input fields for Name and Relationship to Applicant]

ADDRESS CITY STATE ZIP

[Text input fields for Address, City, State, and ZIP]

HOME PHONE CELL PHONE EMAIL

[Text input fields for Home Phone, Cell Phone, and Email]



6 Emergency Contacts (continued)

B Contact B

NAME RELATIONSHIP TO APPLICANT

ADDRESS CITY STATE ZIP

HOME PHONE CELL PHONE EMAIL

C Contact C

NAME RELATIONSHIP TO APPLICANT

ADDRESS CITY STATE ZIP

HOME PHONE CELL PHONE EMAIL

7 Attending Physician & Hospital

Does the applicant plan to use the Villa's attending physician? Yes No *If no, please specify below.*

NAME PHONE

ADDRESS CITY STATE ZIP

HOSPITAL PREFERENCE CITY



8 Podiatrist (after admission)

NAME		PHONE	
<input type="text"/>		<input type="text"/>	
ADDRESS	CITY	STATE	ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

9 Dentist (after admission)

NAME		PHONE	
<input type="text"/>		<input type="text"/>	
ADDRESS	CITY	STATE	ZIP
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

10 Financial Information

Please attach copies of all current cards.

SOCIAL SECURITY NUMBER	MEDICARE NUMBER	MEDICARE EFFECTIVE DATE
<input type="text"/>	<input type="text"/>	<input type="text"/>

Eligible for Supplemental Security Income (SSI)? Yes No *If yes, attach eligibility letter.*

Eligible for Medi-Cal? Yes No

MEDI-CAL NUMBER	SUPPLEMENTAL INSURANCE
<input type="text"/>	<input type="text"/>

SUPPLEMENTAL INSURANCE EFFECTIVE DATE



11 Monthly Statement Recipient

Who should receive the Villa monthly statement, if not the resident?

NAME

RELATIONSHIP TO APPLICANT

ADDRESS

CITY

STATE

ZIP

HOME PHONE

EMAIL

CELL PHONE

12 Arrangement in Event of Death

MORTUARY NAME

PHONE NUMBER

ADDRESS

CITY

STATE

ZIP

13 Certification & Signature

I hereby certify the information on this form is true and complete.

SIGNATURE OF APPLICANT OR REPRESENTATIVE

DATE