

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 _____

(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