APPLICATION FOR ADMISSION

THE VIRGINIA HOME

APPLICANT'S FULL NAME: _____
Last Middle First Suffix

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

TODAY'S DATE: _____

PLEASE RETURN COMPLETED APPLICATION TO:

Director of Admissions
THE VIRGINIA HOME
1101 Hampton Street
Richmond, Virginia 23220

For Virginia Home Use Only

DATE APPLICATION RECEIVED: _____

DATE APPROVED FOR WAITING LIST: _____

DATE OF ENTRANCE: _____

Telephone (804) 359-4093
FAX (804) 359-8961

APPLICATION FOR ADMISSION

Biographical Information

Applicant Name: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Other _____

Name used by Applicant: _____
Last Middle First Suffix

Date of Birth: _____ Age: _____ Birth Place: _____
Month Day, Year Years City State

Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced

Name of Spouse: _____
Last Middle First Suffix

Spouse's Phone Number: (____)_____ (____)_____ (____)_____
Home Work Cell

Occupation of Spouse: _____

Address of Spouse: _____
Street City State Zip

Name of Parents: _____
Last Middle First Suffix

Father's Full Name: _____
Last Middle First Suffix

Father's Place of Birth: _____
City State

Mother's Maiden Name: _____
Last Middle First Suffix

Mother's Place of Birth: _____
City State

Is Father Living: □ Yes □ No Is Mother Living? □ Yes □ No

If yes, age of parents: _____
Father Mother

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Address of Parents: _____
Street *City* *State* *Zip*

Address of Parents: _____
Street *City* *State* *Zip*

Parent's Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Parent's Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Applicant's Length of Residence in Virginia: _____
Years

APPLICANT'S SOCIAL SECURITY NUMBER: __ __ __ - __ __ - __ __ __ __

Occupation or Former Occupation of Applicant: _____

Religion: _____

Church Affiliation: _____
Name

Address: _____
Street *City* *State* *Zip*

Highest Level of Education: □ Grade □ Highschool □ GED □ College □ Graduate School

Does the applicant own or drive a personal motorized vehicle? □ Yes □ No

Applicant Contact Information

Current Address: _____
Street *City* *State* *Zip*

Previous Address: _____
Street *City* *State* *Zip*

Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Email Address: _____

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Name, Address and Phone Number of Individual representing Applicant (Sponsor) & in case of EMERGENCY:

Name: _____
Last *Middle* *First* *Suffix*

Address: _____
Street *City* *State* *Zip*

Relationship to Resident: _____

Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Email Address: _____

Other Persons to be Contacted in Case of Emergency

Name : _____
Last *Middle* *First* *Suffix*

Address: _____
Street *City* *State* *Zip*

Relationship to Resident: _____

Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Email Address: _____

Work History

Name of Last Employer: _____

Address: _____
Street *City* *State* *Zip*

Name of Previous Employer: _____

Address: _____
Street *City* *State* *Zip*

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Medical History

Nature of Illness: □ MS □ CP □ Spinal Injury □ Other: _____

Primary Care Physician: _____

Address: _____
Street *City* *State* *Zip*

Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Email Address: _____

Specialist Physician: _____

Address: _____
Street *City* *State* *Zip*

Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Email Address: _____

Specialist Physician: _____

Address: _____
Street *City* *State* *Zip*

Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Email Address: _____

Briefly State Reasons For Completing This Application:

_____

_____

_____

_____

_____

_____

_____

Nearest living relatives (Please list below all children, brothers and sisters)

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Name: _____

Address: _____
Street *City* *State* *Zip*

Occupation: _____

Relation to Applicant: _____

Name: _____

Address: _____
Street *City* *State* *Zip*

Occupation: _____

Relation to Applicant: _____

Name: _____

Address: _____
Street *City* *State* *Zip*

Occupation: _____

Relation to Applicant: _____

Name: _____

Address: _____
Street *City* *State* *Zip*

Occupation: _____

Relation to Applicant: _____

Please indicate primary and secondary contacts to be notified of availability for admission

Primary Contact Name: _____

Address: _____
Street *City* *State* *Zip*

Phone Number: (____)_____ (____)_____ (____)_____

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Home *Work* *Cell*

Email Address: _____

Secondary Contact Name: _____

Address: _____
Street *City* *State* *Zip*

Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Email Address: _____

Applicant's Assets and Source of Income

Real estate (please indicate location and brief description): _____

_____

Value of your home: _____ Tax Assessment Value: _____

Land that is included with the home: _____

Number of acres: _____ Tax Value: _____

Value of any other property you own: _____

Is there a mortgage on the property? □ YES □ NO

If so, give the exact amount and details as to who holds it, dates of payment, ect.

_____

Annual net income from real estate: $ _____

Cash Amount: $ _____ Location, including name and address of banks:

_____
Institution Name *Address*

_____
Institution Name *Address*

_____
Institution Name *Address*

Stocks, bonds, or other securities: *(List name and value of each)*

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Income from stocks, bonds, ect.: $ _____

Pensions, annuities, trust fund income, social security benefits, etc.:
(Specify details as to each source)
_____

Income from pensions, annuities, trusts, social security benefits, etc.: $

Health Insurance: □ YES □ NO

If yes, name of Company: _____

Policy or Group Number: _____

Funeral Director Designated: _____

Cemetery Lot: □ YES □ NO If yes location: _____

Cost Responsibility: □ YES □ NO

Name: _____

Address: _____
Street *City* *State* *Zip*

Phone Number: (____)_____ (____)_____ (____)_____
Home *Work* *Cell*

Life Insurance Policies: □ YES □ NO

1. Amount: _____ Date: _____ Name of Company: _____

Amount of Annual Premium Payable: □ Weekly □ Monthly □ Yearly

Is policy paid up in full? □ YES □ NO

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Cash surrender value of policy: _____

2. Amount : _____ Date: _____ Name of Company: _____

Amount of Annual Premium: Payable □ Weekly □ Monthly □ Yearly

Is policy paid up in full? □ YES □ NO

Cash surrender value of policy: _____

All other Assets:

Amount of Income: _____
Per Month *Per Year*

State source and amount of all financial assistance now received from:

Relatives or Friends Name: _____

Amount per Month: $ _____

Approved for Medicare: □ Part A □ Part B □ Part D

Medicare Number: _____

Approved for Medicaid: □ YES □ NO

Medicaid Number: _____

Other Assets or Income : $ _____

Applicant's estimated total annual net income from all sources: $_____/Year

I realize that the above information is given for the purpose of my admission as a resident at The Virginia Home and that the Home is entitled to rely on such information in considering this application. Accordingly, I declare that the foregoing contains a complete statement of my financial condition and that all such information is true. I hereby authorize any person or organization mentioned above to provide The Home with any information pertaining to this application.

I declare that I have carefully read the *Rules and Conditions of Admission* and that if accepted as a resident at The Home, I will comply fully and loyally with all its' rules and regulations.

_____ _____

Signature of Applicant *Date*

Name and Address of Person completing application if other than applicant:

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Name: _____

Address: _____
Street City State Zip

I hereby give permission for the release of any information concerning my mental or physical condition to The Virginia Home.

_____ _____

Witness Signature of Applicant

List hospitals and nursing homes where applicant has been a resident or patient:

Institution Name: _____

Address: _____
Street City State Zip

Date: _____

Institution Name: _____

Address: _____
Street City State Zip

Date: _____

Institution Name: _____

Address: _____
Street City State Zip

Date: _____

Applicant's Present Abilities

Ability to turn self in bed? □ Yes □ No
Ability to transfer from bed to chair, and back? □ Yes □ No
Self-propulsion of wheelchair? □Yes □ No
Ambulation by: □ Parallel Bars □ Walker □ Cane/Crutches □Braces □ Independent □N/A
Personal hygiene care □ Yes □ No
Self-care at toilet □Yes □ No
How to dress self? □Yes □ No
How to feed self? □Yes □ No
Use of special appliances for feeding? □Yes □No
Already rehabilitated in Activities of daily living in hospital or rehab center? □Yes No □
If yes please specify facility name and address:
Institution Name: _____

Address: _____
Street City State Zip

Dates of Rehabilitation: _____

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