

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: _____

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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