WILLOW VALLEY
COMMUNITIES

Welcome Center
450 Willow Valley Lakes Drive
Willow Street, PA 17584-9456

# APPLICATION FOR RESIDENCY

Thank you for your interest in residency at Willow Valley Communities.

The attached application forms request personal and financial information and information about any current needs you may have. Each applicant, if there is more than one, must **personally** complete an individual application.

Please complete and sign the entire application, including the financial information and medical self-assessment, and submit them to your Sales Counselor.

The Preadmission Medical Form should be taken to your Primary Care Physician. Once completed, please return the form to Willow Valley Communities.

In addition to these forms, please submit the following as part of your application packet:

- Check/money order for $400 per person as a non-refundable application processing fee
- Photocopy of the front and back of your Medicare card and supplemental insurance cards (medical and prescription)

**Please note:**

- If you list a trust among your assets, the Manager of Sales may request trust documents for review.
- The first 120 days of residency are considered an "adjustment period," as outlined in the Resident's Agreement.
- The Entrance Fee is paid in three segments, as outlined in the Resident's Agreement.
- The Monthly Service Fee is paid on a monthly basis as outlined in the Resident's Agreement.

WILLOW VALLEY COMMUNITIES

# APPLICATION FOR ADMISSION
# SECTION I: ACKNOWLEDGEMENT

*All forms must be completed by each applicant in the case of double occupancy*

- I seek admission to the Community, a continuing care retirement community regulated by the Pennsylvania Department of Insurance.
- I understand that this information will be treated as confidential and will not be disclosed to a party unrelated to Willow Valley Communities without my authorization except to the extent necessary to evaluate my Application for Residency.
- I am aware that my admission to the Community requires an assessment for long-term care risk. I also understand that if such assessment results in my being placed in a high-risk category, I may be determined to be ineligible for admission to the residential component and may be offered admission to another level of living.
- I agree that the Admissions Committee decision rendered shall be final and binding.
- I understand that completion of this Application is a prerequisite to admission to the Community and that any misrepresentation or omission of information in the attached forms may result in my denial of admission to the Community or termination of my Resident's Agreement with Willow Valley Communities.
- I understand that any failure by my physician to disclose information that is material to my eligibility for admission may result in my denial of admission to the Community or termination of my Resident's Agreement with Willow Valley Communities.

**Applicant's Name (Printed)**_____

**Applicant's Signature**_____

**Date**_____


## APPLICATION FOR ADMISSION
## SECTION II: GENERAL INFORMATION

Applicant's Name: _____

Home Phone#: (_____)_____Cell Phone#: (_____)_____

Address:_____

City:_____State:_____Zip:_____

Email: _____

Date of Birth:_____Age:_____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

**If the case of double occupancy:**

Name of Co-Applicant: _____

WILLOW VALLEY COMMUNITIES

# APPLICATION FOR ADMISSION
# SECTION III: FINANCIAL INFORMATION

*A separate form should be completed by each applicant*
*List the full value of joint assets on each application and mark as "Joint" under description*

**NAME:** _____ **DOB:** _____ **Sex: M ☐ F ☐**

| **REGULAR MONTHLY INCOME** | | **Description (if needed)** |
|---|---|---|
| **Social Security** ***(Net)*** | **$_____Per Month** | _____ |
| **Pension** | **$_____Per Month** | _____ |
| **Pension from Spouse** ***(If collecting survivor benefit)*** | **$_____Per Month** | _____ |
| **Annuity Income** | **$_____Per Month** | **# of years**_____ |
| **Other Income** ***(Not from capital assets such as IRA, etc.)*** | **$_____Per Month** | _____ |
| **TOTAL INCOME:** | **$_____Per Month** | |

| **CAPITAL ASSETS (Value)** | | **Description (if needed)** |
|---|---|---|
| **Primary Residence** | **$_____** | _____ |
| **Real Estate** | **$_____** | _____ |
| **Cash/Savings/CDs** | **$_____** | _____ |
| **Stocks/Equity Funds** | **$_____** | _____ |
| **Bonds/Bond Funds** | **$_____** | _____ |
| **IRA/401K** | **$_____** | _____ |
| **Roth IRA** | **$_____** | _____ |
| **Other** | **$_____** | _____ |
| **TOTAL ASSETS:** | **$_____** | |

| **LIABILITIES** | | **Description (if needed)** |
|---|---|---|
| **Mortgage** | **$_____** | _____ |
| **Notes Payable/Endorsed** | **$_____** | _____ |
| **Personal Debts** ***(Including credit cards)*** | **$_____** | _____ |
| **TOTAL LIABILITIES:** | **$_____** | |

**Signature:** _____ **Date:** _____

***Failure to completely and accurately disclose financial information may constitute grounds for termination of residency.***

WILLOW VALLEY COMMUNITIES

# SECTION IV: AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

**Applicant's Name: _____ DOB: _____**

I hereby authorize the use and disclosure of protected health information about the above Applicant as follows:

**A. Name of person, class of persons, or organization authorized to make the requested disclosure:**

Name of Primary Care Physician: _____

**B. Name of person, class of persons, or organization authorized to receive and use my protected health information:**

Willow Valley Communities

**C. Description of Applicant's protected health information to be disclosed:**

Medical records, medical histories, mental health records, laboratory results, progress notes, physicians' orders, and lists of medications.

**D. Applicant's protected health information is being disclosed for the following purpose(s):**

To determine Applicant's eligibility for admission to Willow Valley Communities, identify Applicant's personal needs, and develop a plan of accommodation for Applicant if needed.

I understand that I have the following rights with respect to this Authorization:

1. The recipient of the protected health information may not further disclose the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.
2. I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.
3. Provider will provide me with a copy of this Authorization.
4. I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to the attention of the Move Counselor at Willow Valley Communities, 450 Willow Valley Lakes Drive, Willow Street, PA 17584-9456. Such revocation will be effective upon receipt, except to the extent that the recipient has taken action in reliance on this Authorization. I understand that such revocation will be considered a withdrawal of my Application for Residency.

**Applicant's Signature_____Date:_____**

**Address: _____**

**Telephone # :(_____) _____**

## SECTION V: INFORMATION FOR LIFECARE COVERAGE

*Confidential*

**Applicant's Name: _____DOB: _____**

Because the Willow Valley Communities Resident's Agreement provides Lifecare to all residents of the Community, it essentially "self-insures" for many of the health care risks of residents. The questions on the attached form are intended to help Willow Valley Communities determine whether you are likely to require another level of living that would jeopardize the financial soundness of Willow Valley Communities' self-insured health plan for residents.

The answers to these questions may also assist Willow Valley Communities in determining ways in which your needs may be reasonably accommodated.

**Willow Valley Communities must be notified of any changes in your health status. Failure to disclose information may result in denial of your application or the termination of your residency.**

Please answer the questions as fully and candidly as you can to help Willow Valley Communities Admissions Committee evaluate the appropriateness of the Community to your needs.

WILLOW VALLEY COMMUNITIES

# MEDICAL SELF-ASSESSMENT

*Please answer all questions and sign as indicated*

**APPLICANT'S NAME:** _____ **DOB:**_____

**Primary Physician:**_____ **Phone#:(_____)**_____

**Physician's Address:** _____

**Date of last appointment and reason:**_____

**Specialty Physician:**_____ **Phone#:(_____)** _____

**Physician's Address:** _____

**Date of last appointment and reason:**_____

**Specialty Physician:**_____ **Phone#:(_____)** _____

**Physician's Address:** _____

**Date of last appointment and reason:**_____

## Health Information

Please **check** "Yes" or "No" box and **circle** specific conditions listed for which you have received treatment **within the past 5 years**. Provide details for all "yes" answers.

□ **Yes** □ **No** 1. Heart disease/disorder of vascular disorder, high blood pressure, high cholesterol, coronary artery disease, heart attack, congestive heart failure (CHF), irregular heartbeat, palpitations, atrial fibrillation or other arrhythmia, leg swelling, stents, or other heart surgery

_____

_____

□ **Yes** □ **No** 2. Diabetes or disorder of glucose metabolism, use of oral diabetes medication, insulin use, parathyroid or other endocrine gland condition

_____

□ **Yes** □ **No** 3. Genitourinary disease, kidney disease, dialysis, cystitis, neurogenic bladder, uterine or bladder prolapse, urinary incontinence/accidents, prostate problems

_____

□ **Yes** □ **No** 4. Gastric conditions: esophageal or stomach ulcers, liver disease, cirrhosis, hepatitis, Crohn's disease, bowel incontinence/accidents, ostomy, intestinal surgery

_____

## MEDICAL SELF-ASSESSMENT (continued)

Applicant's Name:_____

□ **Yes** □ **No** 5. Cancer, any type: breast, colon, prostate, lymphoma, leukemia, Hodgkin's disease, lung, skin, melanoma (not basal cell or squamous carcinoma), bone, recurrence of cancer or spread of cancer to another organ/site

□ **Yes** □ **No** 6. Bone, joint, or muscle conditions: arthritis (rheumatoid or osteo), degenerative joint disease, Paget's disease, osteoporosis, fractures, joint replacements, chronic pain, fibromyalgia

□ **Yes** □ **No** 7. Breathing/lung/respiratory conditions: emphysema, chronic bronchitis, chronic obstructive pulmonary disease (COPD), asthma, pulmonary fibrosis, tuberculosis (TB), sleep apnea

□ **Yes** □ **No** 8. Brain injury or disease, stroke, transient ischemic attacks (TIA or "mini stroke"), carotid artery blockage

□ **Yes** □ **No** 9. Forgetfulness, confusion, mild cognitive impairment (MCI), Alzheimer's disease, dementia, memory loss

□ **Yes** □ **No** 10. Mental, nervous, or emotional disorder: anxiety, depression, schizophrenia, bipolar disorder, alcohol or drug abuse

□ **Yes** □ **No** 11. Neurological conditions: Parkinson's disease, multiple sclerosis, Guillain-Barré, Lou Gehrig's disease (ALS), muscular dystrophy, tremors, paralysis, weakness

□ **Yes** □ **No** 12. Immune system conditions: systemic lupus erythematosus (SLE), discoid lupus (involving skin only)

□ **Yes** □ **No** 13. Eye/ear/nose conditions: blindness, deafness, glaucoma, Meniere's disease, dizziness, macular degeneration

□ **Yes** □ **No** 14. Blood disease: anemia, thrombocytopenia, etc.

□ **Yes** □ **No** 15. Any other conditions not mentioned above:

*Describe:*

□ **Yes** □ **No** 16. Within the past 5 years, have you ever had or been advised to have surgery, special diagnostic testing or treatments?

*If "Yes", explain:*

□ **Yes** □ **No** 17. Have you ever been evaluated or treated by a neurologist or geriatric psychiatrist?

*If "Yes", give date and reason:*

# MEDICAL SELF-ASSESSMENT (continued)

Applicant's Name:_____

□ **Yes** □ **No** 18. Have you ever taken part in or been referred to a program for drug or alcohol abuse or mental health treatment?

*If "Yes", provide details:*

□ **Yes** □ **No** 19. Within the past 5 years, have you received care in a nursing facility?

*If "Yes", provide dates. From* _____ *to* _____

*Reason:*

□ **Yes** □ **No** 20. Within the past 5 years, have you received caregiver assistance from family, friends, or an outside agency?

*If "Yes", provide dates. From* _____ *to* _____

*Reason:*

□ **Yes** □ **No** 21. Within the past 5 years, have you received physical therapy or home health care services?

*If "Yes", provide dates. From* _____ *to* _____

*Reason:*

□ **Yes** □ **No** 22. In an emergency, are you able to exit a residence without the assistance of a person or device?

*If "No", explain:*

□ **Yes** □ **No** 23. Do you wear hearing aids, glasses, or contacts?

*If "Yes", provide details:*

□ **Yes** □ **No** 24. Do you have a history of falling?

*If "Yes", how often?*

25. How far can you walk without stopping to rest?

_____ *City Blocks or* _____ *Miles*

□ **Yes** □ **No** 26. Can you climb a flight of steps without pain, tiredness, or shortness of breath?

*If "No", explain:*

27. Please list any dietary needs:

□ **Yes** □ **No** 28. Do you drink alcoholic beverages?

*If "Yes", how much and what type?*

□ **Yes** □ **No** 29. Have you used tobacco products: cigarettes, pipes, cigars, or smokeless products such as e-cigarettes in the last 12 months?

*If "Yes", what type?*

*Amount per day* _____ *How long?* _____ *If you quit, when?* _____

**Please note: Smoking is not permitted at Willow Valley Communities, including all buildings, residences, and grounds**

# MEDICAL SELF-ASSESSMENT (continued)

Applicant's Name:_____

**Check all activities below for which you need assistance**

□ Transferring (bed to chair)
□ Bathing
□ Dressing
□ Feeding self
□ Toileting
□ Using the telephone
□ Driving or utilizing other transportation
□ Taking Medications
□ Shopping
□ Meal preparation
□ Light housekeeping
□ Managing Appointments
□ Handling cash resources/finances
□ Managing urinary & bowel incontinence (including catheter care, ostomies)

Explain: _____

**Activity**

□ **Yes** □ **No** Do you exercise?

*If "Yes", what type of exercise do you enjoy and how frequently?*

_____

_____

_____

# MEDICAL SELF-ASSESSMENT (continued)

Applicant's Name:_____

## Medications

| List all prescription and non-prescription medications and supplements you currently take. | | | |
|---|---|---|---|
| **Name of Medication** | **Dose** | **Frequency** | **Purpose of Medication** |
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□ **Yes** □ **No** If any medication requires injection, do you prepare it and inject yourself independently?

*If "No", who assists you?*

*How often?*

□ **Yes** □ **No** If you are diabetic, do you check your fasting blood sugars independently?

*If "No", who assists you?*

*How often?*

Applicant, if you have been assisted with completing this questionnaire, list name(s) and relationship

_____

I certify that the answers and information I have provided in this questionnaire are true and complete to the best of my knowledge and belief.

**Applicant's Signature: _____ Date: _____**