Glen Haven Village
IN MEMORY OF
DON & MURIEL RHODEN

Application for Residency

Resident Name: _____

Address: _____Telephone:_____

City: _____ State: _____ Zip: _____

Primary Insurance: _____ Secondary Insurance: _____

Other Coverage: _____

I have the following advanced directives in place:
☐Financial POA ☐HealthCarePOA ☐ Guardian
☐Living Will ☐Other:_____

Contact Person: _____ Relationship: _____
(In the event applicant is unable to be reached)

Address: _____ Telephone: _____

_____ I understand the facility will request clinical information from my healthcare
Initials providers including but not limited to my most recent History & Physical, current medications and treatments, recent hospitalizations and visit notes and that the resident must be approved clinically prior to admission.

Primary Care Physician: _____ Home Health Agency:_____

Specialists involved in my care: _____

Room Preference: □ Private □ Companion
Memory Supportive Care Need: □ Yes □ No

_____ I understand that the completed Financial Profile form is due at time of
Initials admission to facility.

A facility representative has spoken with me about rates and based on the costs of care I:
□ Will □ Will Not need to complete a Medicaid Application to pay for my care.

Along with this completed application form, please enclose a sincerity deposit of $1000.00. This amount will go toward the first month of care. If admission criteria is not met or you make a decision not to move in, the deposit will be refunded in full.

Applicant Signature: _____ Date: _____

Relationship to Resident: _____

Facility Representative: _____ Date: _____

_____Sincerity Deposit Received
Facility Rep Initials

_____Wait List Updated
Facility Rep Initials