

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

# *The Virginian*



## APPLICATION *for* RESIDENCY

9229 Arlington Boulevard • Fairfax, Virginia 22031  
703-385-0555 *phone* • 703-383-1826 *fax* • [www.thevirginian.org](http://www.thevirginian.org)

___ Life Care Plan ___ Monthly Care Plan	Anticipated Move-in Date:
___ Independent Living	___ Studio (Assisted Living Only)
___ Independent Living Respite	___ One Bedroom & One Bath
___ Assisted Living	___ One Bedroom & One Bath with Balcony
___ Assisted Living Respite	___ Two Bedroom & One Bath
___ Health Care Center	___ Two Bedroom & Two Bath
___ Health Care Center Respite	___ Two Bedroom & Two Bath Custom

## PERSONAL HISTORY

*Application to be completed in Blue or Black ink only.*

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Street Address: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Other) \_\_\_\_\_

Email address: \_\_\_\_\_

Marital Status: \_\_\_ Married \_\_\_ Widowed \_\_\_ Divorced \_\_\_ Separated \_\_\_ Single

Number of Children: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Citizen of: \_\_\_\_\_

Father's Name: \_\_\_\_\_ Mother's Name: \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Your Previous Occupation: \_\_\_\_\_

Religious Denomination: \_\_\_\_\_

Place of Worship: \_\_\_\_\_ Pastor: \_\_\_\_\_

Pastor's Telephone: \_\_\_\_\_

Education Level: (circle one) High School / Undergraduate / Graduate / Ph. D

Are you a Veteran? \_\_\_ Yes \_\_\_ No If yes, Branch and dates of service: \_\_\_\_\_

Do you drive? \_\_\_ Yes \_\_\_ No License Plate Number: \_\_\_\_\_ State: \_\_\_\_\_

Year of Car: \_\_\_\_\_ Make of Car: \_\_\_\_\_ Model: \_\_\_\_\_

Do you have any pets you intend to bring with you? \_\_\_ Yes \_\_\_ No

If "YES", please list animal breed, weight, and age: \_\_\_\_\_

Special hobbies or interests: \_\_\_\_\_

How did you hear about The Virginian? \_\_\_\_\_

# ACKNOWLEDGEMENT

*I make this application of my own free will and accord. I have read, or have had read to me the completed application and I fully understand the questions herein asked and all the requirements for admission to The Virginian. I declare the answers to the foregoing questions to include the Financial Statement, the Medical History, and the Insurance information to be true, full, and complete. I understand that my application will not be submitted to the Admissions Committee of the Board of Directors until it is complete. I realize that any false statement or misrepresentation in this application may result in the termination of the Residence and Care Agreement by the corporation.*

Full Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

If this application was completed by someone other than the applicant, the undersigned certifies that the information provided by the applicant is true, full, and complete.

Full Name of person completing this form (please print):

Relationship to Applicant: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

## **Upon submission of application, please include \$100 application fee along with copies of the following:**

- Medicare Card (front & back copies required)
- Supplemental pharmacy and all other insurance cards (front & back copies required)
- Durable Power of Attorney for Finance and Healthcare
- Living Will (if applicable)
- Trust (if applicable)
- Verification of all assets listed on Confidential Financial Statement

**Applications must be fully completed for consideration. Incomplete applications will be returned for completion.**

*The Virginian is open to persons of both sexes and to members of all religious denominations. Admission is open to applicants regardless of race, color, nationality, origin or creed. Each applicant will be considered on his/her own merits. Upon receipt of the application, your request for residency will be reviewed and may be recommended for consideration by the Admissions Committee of the Board of Directors.*

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_



CONFIDENTIAL  
FINANCIAL  
STATEMENT

# CONFIDENTIAL FINANCIAL STATEMENT – Part I

Verification of the Capital Assets and Net Monthly Income listed below is required. Financial documents that are acceptable for the verification of assets include the most current bank and/or brokerage statements and property tax assessments or real estate sale agreement. For certificates of deposit (CDs), a statement from the bank outlining the certificate number, the amount of the certificate at maturity, and the maturity date is required. Additional financial information may be requested.

List of Capital Assets		List of Net Income	
Cash (Savings and Checking)	\$	Social Security	\$ per month
Stocks and Bonds	\$	Pension	\$ per month
Home	\$	Rental Income	\$ per month
Other Real Estate	\$	Mortgage Income	\$ per month
(Describe Other Real Estate)		Other Income	\$ per month
Other Investments	\$	TOTAL Net Income	\$ per month
(Describe Other Investments)			
Revocable Trust	\$		
Irrevocable Trust	\$		
<b>TOTAL Capital Assets</b>	<b>\$</b>		

Please identify any jointly owned assets listed above and provide contact information and type of ownership (*tenants by the entirety, joint tenant with survivorship, tenants in common, pay on death, bank or securities account etc.*) for joint owner.

Asset: \_\_\_\_\_ Type of Ownership: \_\_\_\_\_

Joint Owner Name: \_\_\_\_\_

Telephone: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Are any of the assets listed in trust?  Yes  No

If "YES" please identify such assets, contact information of trustee and copy of trust:

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## CONFIDENTIAL FINANCIAL STATEMENT - Part II

List of Liabilities	Total Amount	Monthly Payments
Mortgages	\$	per month
Notes Payable	\$	per month
Notes Endorsed / Guaranteed	\$	per month
Credit Card Debt(s)	\$	per month
Personal Debt(s)	\$	per month
Other	\$	per month
(Describe Other)		
TOTAL Liabilities	\$	per month
TOTAL Net Worth (TOTAL assets less TOTAL liabilities)		\$

Do you have any contingent liabilities (*guaranteeing payment of another person's debt*)?

Yes  No

If "YES", please give full particulars:

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Are you obligated by court order, agreement in writing, or otherwise to pay for another person's support?  Yes  No

If "YES", please give full particulars:

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# CONFIDENTIAL FINANCIAL STATEMENT – Part III

Are you currently receiving, or have you ever received disability income, Social Security Disability or Worker's Compensation benefits? \_\_\_\_ Yes \_\_\_\_ No

A Power of Attorney is required as a condition of residency at The Virginian. If you do not have a POA, information can be provided to you on how to obtain one.

## Financial Power of Attorney Information

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

## Substitute or Secondary Financial Power of Attorney Information

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Do you have a Durable Power of Attorney for Health Care? \_\_\_\_ Yes \_\_\_\_ No

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Do you have a Secondary Durable Power of Attorney for Health Care? \_\_\_\_ Yes \_\_\_\_ No

Name: \_\_\_\_\_ Email: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Do you have a Living Will? \_\_\_\_ Yes \_\_\_\_ No

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_



MEDICAL HISTORY *and*  
INSURANCE INFORMATION

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# INSURANCE INFORMATION - Part I

Do you have Medicare part A?  Yes  No

Do you have Medicare part B?  Yes  No

Do you have Medicare part D?  Yes  No

Medicare Number: \_\_\_\_\_

Have you assigned your Medicare to an HMO?  Yes  No

Have you assigned your Medicare to a PPO?  Yes  No

Have you assigned your Medicare to a PFS?  Yes  No

Do you have supplemental health insurance?  Yes  No

Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Do you have long term care health insurance?  Yes  No

If "YES" Please attach copy of benefit summary.

Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Do you have any other health insurance?  Yes  No

Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Do you have prescription drug insurance?  Yes  No

Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_

Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

# INSURANCE INFORMATION - Part II

## Emergency Contacts

In case of emergency or death, please notify:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Email: \_\_\_\_\_

# PRIVATE ARRANGEMENTS - Part III

## Private Arrangements

Location of Will and name, address, and telephone of Executor:

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Funeral Home Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_

If you have made arrangements to be an organ donor, please provide specifics:

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# CONFIDENTIAL MEDICAL HISTORY – Part I

We realize that some of this information may change once you move to The Virginian and request that you provide us with updates at the time of the changes. Thank you in advance for your cooperation.

Date of last physical examination: \_\_\_\_\_

Primary Physician: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Alternate Physician/Specialist: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Dentist: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Describe any specialized medical care that you are currently receiving:

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# CONFIDENTIAL MEDICAL HISTORY - Part II

Do you currently use any of the following?

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Wheelchair       | <input type="checkbox"/> Walker       | <input type="checkbox"/> Quad Cane        |
| <input type="checkbox"/> Dialysis Machine | <input type="checkbox"/> Oxygen       | <input type="checkbox"/> Hearing Aid      |
| <input type="checkbox"/> Eyeglasses       | <input type="checkbox"/> Hospital Bed | <input type="checkbox"/> Electric Scooter |
| <input type="checkbox"/> Pacemaker        | <input type="checkbox"/> Guide Animal | <input type="checkbox"/> Dentures         |

Please explain any items checked YES:

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Do you need, receive assistance or supervision from another person in performing any of the following activities of daily living?

- |                                     |  |                                       |
|-------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Ambulation | <input type="checkbox"/> Dressing                  | <input type="checkbox"/> Bathing      |
| <input type="checkbox"/> Grooming   | <input type="checkbox"/> Medication Administration | <input type="checkbox"/> Eating       |
| <input type="checkbox"/> Cooking    | <input type="checkbox"/> Toileting                 | <input type="checkbox"/> Laundry      |
| <input type="checkbox"/> Shopping   | <input type="checkbox"/> Transportation            | <input type="checkbox"/> Housekeeping |
| <input type="checkbox"/> Finances   | <input type="checkbox"/> Transferring              |                                       |

Please explain any items checked YES:

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Family History:

- |  |                                       |  |
|--|---------------------------------------|--|
| <input type="checkbox"/> Allergies       | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Gout          |
| <input type="checkbox"/> Kidney Ailments | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Diabetes      |
| <input type="checkbox"/> Hypertension    | <input type="checkbox"/> Stroke       | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Rheumatism      | <input type="checkbox"/> Tuberculosis |  |

Comments:

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# CONFIDENTIAL MEDICAL HISTORY - Part III

Do you have, or have you ever had any of the following medical conditions?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Memory Loss           | <input type="checkbox"/> Dementia             | <input type="checkbox"/> Mental Illness             |
| <input type="checkbox"/> Depression            | <input type="checkbox"/> Arthritis            | <input type="checkbox"/> Fractures                  |
| <input type="checkbox"/> Asthma                | <input type="checkbox"/> Tuberculosis         | <input type="checkbox"/> Lung Conditions            |
| <input type="checkbox"/> Emphysema             | <input type="checkbox"/> Bleeding Disorder    | <input type="checkbox"/> Blood Disease              |
| <input type="checkbox"/> Clotting Disorder     | <input type="checkbox"/> Sickle Cell Anemia   | <input type="checkbox"/> Hemodialysis               |
| <input type="checkbox"/> Hemolytic Anemia      | <input type="checkbox"/> Leukemia             | <input type="checkbox"/> Cancer                     |
| <input type="checkbox"/> Lymphoma              | <input type="checkbox"/> Myasthenia Gravis    | <input type="checkbox"/> Parkinson's Disease        |
| <input type="checkbox"/> Renal Failure         | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Seizure Disorder           |
| <input type="checkbox"/> Stroke                | <input type="checkbox"/> Head Injuries        | <input type="checkbox"/> Liver Disease              |
| <input type="checkbox"/> Laryngectomy          | <input type="checkbox"/> Eye Surgery          | <input type="checkbox"/> Glaucoma                   |
| <input type="checkbox"/> Stomach Ulcer         | <input type="checkbox"/> Hearing Impairment   | <input type="checkbox"/> Heart Valve Prosthesis     |
| <input type="checkbox"/> Angina                | <input type="checkbox"/> Cardiac Dysrhythmia  | <input type="checkbox"/> Pacemaker                  |
| <input type="checkbox"/> Hypertension          | <input type="checkbox"/> Coronary Bypass      | <input type="checkbox"/> Heart Abnormalities        |
| <input type="checkbox"/> Adrenal Insufficiency | <input type="checkbox"/> Hypoglycemia         | <input type="checkbox"/> Alcoholism                 |
| <input type="checkbox"/> Chemical Dependency   | <input type="checkbox"/> Macular Degeneration | <input type="checkbox"/> Diabetes/Insulin Dependent |

Explain any chronic diseases or other medical conditions that you may have listed above or that are not listed:

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Are you a current smoker?  Yes  No

If "YES", how many cigarettes per day? \_\_\_\_\_

# CONFIDENTIAL MEDICAL HISTORY - Part IV

List your current medications and dosage:

Medication	Dosage	Time

Are you allergic to any of the following? If "YES", please describe reaction:

- |   |  |                                       |
|---|--|---------------------------------------|
| <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Barbituates   | <input type="checkbox"/> Codeine      |
| <input type="checkbox"/> Demerol            | <input type="checkbox"/> Environmental | <input type="checkbox"/> Horse Serum  |
| <input type="checkbox"/> Insect Stings      | <input type="checkbox"/> Latex         | <input type="checkbox"/> Lidocaine    |
| <input type="checkbox"/> Novacaine          | <input type="checkbox"/> Sulfa         | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> X-Ray Dyes         | <input type="checkbox"/> Penicillin    | <input type="checkbox"/> Eggs         |
| <input type="checkbox"/> No Known Allergies |  |                                       |

Other: \_\_\_\_\_

Reaction: \_\_\_\_\_

Describe any surgical procedures, serious illnesses, and/or hospitalizations within 5-10 years:

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During the last two years have you received home health care, been medically advised to enter a nursing home, or been confined to a hospital or other health care facility?  Yes  No

If "YES", please describe: \_\_\_\_\_

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