

Oakwood Village Continuing Care Retirement Communities - Application for Residency

Oakwood Village West
 6205 Mineral Point Road
 Madison, WI 53705
 (608) 230-4699
 Fax (608) 230-3284



Continuing Care Retirement Communities

Oakwood Village East
 5565 Tancho Drive
 Madison, WI 53718
 (608) 230-4000
 Fax (608) 230-4001

I AM APPLYING FOR: (I've submitted my refundable application fee in the amount shown below)

OAKWOOD VILLAGE WEST

___ Memory Care/CBRF (\$500)
 ___ Assisted Living/CBRF (\$500)
 ___ Gallery/Towers Apartment (\$1,000)
 Style Preference: _____
 ___ Apartment Homes (\$1,000)
 Style Preference: _____

OAKWOOD VILLAGE EAST

___ Advanced Assisted Living/CBRF (\$500)
 ___ Assisted Living/CBRF (\$500)
 ___ Memory Care/CBRF (\$500)
 ___ Apartment Homes (\$1,000)
 Style Preference: _____

| GENERAL INFORMATION: | APPLICANT #1 | APPLICANT #2 |
|--------------------------------|--|--|
| Legal Last Name | _____ | _____ |
| Legal First Name | _____ | _____ |
| Legal Middle Name | _____ | _____ |
| Preferred Name | _____ | _____ |
| Street Address | _____ | _____ |
| City, State, Zip | _____ | _____ |
| Telephone - Home | _____ | _____ |
| Cell/Work | _____ | _____ |
| E-mail | _____ | _____ |
| Sex | <input type="checkbox"/> Male <input type="checkbox"/> Female | <input type="checkbox"/> Male <input type="checkbox"/> Female |
| Social Security Number | _____ | _____ |
| Marital Status | _____ | _____ |
| Birth Date | _____ | _____ |
| Current Age | _____ | _____ |
| Birthplace | _____ | _____ |
| Former/Current Occupation | _____ | _____ |
| Have you ever resided in? | <input type="checkbox"/> Retirement Apartments <input type="checkbox"/> Assisted Living (CBRF) <input type="checkbox"/> Skilled Nursing Facility | <input type="checkbox"/> Retirement Apartments <input type="checkbox"/> Assisted Living (CBRF) <input type="checkbox"/> Skilled Nursing Facility |
| Date of Last Nursing Home Stay | _____ | _____ |
| Religion | _____ | _____ |
| Church Name: | _____ | _____ |
| Address | _____ | _____ |
| City, State, Zip | _____ | _____ |
| Telephone | _____ | _____ |
| Contact Name | _____ | _____ |

HEALTH CARE INFORMATION:

APPLICANT #1

APPLICANT #2

If information is the same for applicant #2, please write "same."

Physician

| | | |
|------------------|-------|-------|
| Name | _____ | _____ |
| Clinic Name | _____ | _____ |
| Address | _____ | _____ |
| City, State, Zip | _____ | _____ |
| Telephone | _____ | _____ |
| Fax | _____ | _____ |

Dentist

| | | |
|------------------|-------|-------|
| Name | _____ | _____ |
| Clinic Name | _____ | _____ |
| Address | _____ | _____ |
| City, State, Zip | _____ | _____ |
| Telephone | _____ | _____ |

Hospital Preference

| | | |
|------|-------|-------|
| Name | _____ | _____ |
|------|-------|-------|

Funeral Home

| | | |
|------------------|-------|-------|
| Name | _____ | _____ |
| Address | _____ | _____ |
| City, State, Zip | _____ | _____ |
| Telephone | _____ | _____ |

Have you executed any of the following?

| | | | | |
|------------------------------|------------------------------|-----------------------------|------------------------------|-----------------------------|
| Power of Attorney-Healthcare | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Financial Power of Attorney | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Burial Trust | <input type="checkbox"/> Yes | <input type="checkbox"/> No | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Have you transferred money or made a large financial gift greater than \$5,000 to anyone within the past five years?

Please Describe: _____

Insurance:

a) Health insurance coverage—name of carrier and policy number:

_____ (Attach copy of card)

b) Medicare Health Insurance Number, if applicable:

_____ (Attach copy of card)

c) Medicaid Insurance Number, if applicable:

_____ (Attach copy of card)

NOTE: The following information is extremely important. We must be provided with the name of the person(s) who are responsible for your financial payments and for emergency contacts.

| CONTACT INFORMATION: | APPLICANT #1 | APPLICANT #2 |
|-----------------------------|---------------------|---------------------|
|-----------------------------|---------------------|---------------------|

Will applicant be handling his/her own financial matters at Oakwood? Yes No Yes No

If not, please identify the responsible party *(Please provide copy of Financial Power of Attorney)*

| | | |
|---------------------------|-------|-------|
| Name | _____ | _____ |
| Address | _____ | _____ |
| City, State, Zip | _____ | _____ |
| Telephone | _____ | _____ |
| Relationship to Applicant | _____ | _____ |
| E-mail | _____ | _____ |

EMERGENCY CONTACT #1

| | | |
|---------------------------|-------|-------|
| Name | _____ | _____ |
| Address | _____ | _____ |
| City, State, Zip | _____ | _____ |
| Telephone | _____ | _____ |
| Relationship to Applicant | _____ | _____ |
| E-mail | _____ | _____ |

EMERGENCY CONTACT #2

| | | |
|---------------------------|-------|-------|
| Name | _____ | _____ |
| Address | _____ | _____ |
| City, State, Zip | _____ | _____ |
| Telephone | _____ | _____ |
| Relationship to Applicant | _____ | _____ |
| E-mail | _____ | _____ |

| | | |
|---|---|---|
| In case of death, who has legal authority to handle the applicant's affairs? | <input type="checkbox"/> Responsible Party | <input type="checkbox"/> Responsible Party |
| | <input type="checkbox"/> Emergency Contact #1 | <input type="checkbox"/> Emergency Contact #1 |
| | <input type="checkbox"/> Emergency Contact #2 | <input type="checkbox"/> Emergency Contact #2 |
| | <input type="checkbox"/> Other (list below) | <input type="checkbox"/> Other (list below) |

Please identify if other: _____

How did you learn about Oakwood Village: _____

If it was a current resident or advertising, please be specific: _____

SIGNATURE PAGE:

In completing this application, I am aware that

- 1. The information and financial data in this application will be used to determine eligibility for admission to Oakwood Village.
- 2. Oakwood will rely upon and is entitled to rely upon the accuracy of my statements.
- 3. I may be requested to update this application when Oakwood considers it appropriate.

Therefore, I DECLARE THAT THE INFORMATION GIVEN IN THIS APPLICATION IS TRUE, FULL AND COMPLETE. I understand that misrepresentations and material omissions may be grounds for termination of the residency contract.

I give my consent to verify information contained in this application with my doctors, pharmacists, and financial advisors.

Signature of applicant _____ Date _____

Signature of second applicant _____ Date _____

Signature of preparer if other than applicant _____ Date _____

Printed name of preparer if other than applicant _____ Date _____

Capacity of signer: ___ Self ___ Spouse ___ Guardian ___ POA ___ Conservator ___ Trustee

Other (Specify): _____

OAKWOOD VILLAGE reserves the right to accept or reject any applicant for admission. Guidelines for acceptance and participation in Oakwood Village programs are the same for everyone without regard to race, sex, religion, color, sexual orientation, national origin or ancestry, age, disability, marital status or physical appearance, or any other basis prohibited by local, state or federal laws, rules or regulations. Oakwood is an Equal Housing Opportunity community which adheres to all state and federal fair housing laws.

Smoking is not permitted on the campuses of Oakwood Village.



Received by: _____ Date: _____

Deposit received: _____ \$ 500.00 Check number: _____ or

_____ \$1,000.00 Cash: _____

Oakwood is a Lutheran church-sponsored organization whose mission is to serve older persons through loving, caring Christian communities, responding to their physical, social, emotional, intellectual, and spiritual needs, and to encourage a sense of independence, individuality, dignity, and worth throughout life.