

## **IMPORTANT – READ ALL INSTRUCTIONS**

### **INSTRUCTIONS FOR COMPLETION OF APPLICATION**

---

This application consists of three sections, which may be separated for your convenience.

- a) Application for Admission (personal information)
- b) Medical Doctor's Certificate of Examination
- c) Confidential Financial Statement

In the case of a couple, each applicant must complete separate forms.

**PLEASE BE SURE ALL QUESTIONS ARE ANSWERED AND ALL SIGNATURES AFFIXED WHERE NECESSARY.** If any part is incomplete, it will be necessary to delay processing your application until the missing information can be obtained. **If a question does not apply to you, enter "n/a" (not applicable) in that space. Do not leave any answers blank.**

❖ Sign and date the "Release of Confidential Information" section on the first page of the "Medical Doctor's Certificate of Examination". This will insure that we are able to get all the necessary information and records from your doctor.

Remind your doctor that all questions must be answered and copies of the requested reports and test results attached before the application is mailed to us. **Failure to submit any part of the requested information will result in a delay in processing.**

**The following must be submitted with the medical portion of the application. Please stress the importance of this with your physician.**

- a) chest x-ray report
- b) EKG
- c) blood work report (CBC, chem. profile, T4)
- d) urinalysis

After all information is complete, forward all portions of the application **and a copy of your current Elks membership card** to the Elks National Home, 931 Ashland Ave., Bedford, Virginia 24523. Include your check for the \$100.00 application processing fee made payable to the Elks National Home.

**NOTE:** It is not necessary to return the agreement with the completed application. It is enclosed at this time for your information only. You will be required to sign the agreement at a later date after your application is processed.

**IMPORTANT:** The medical information is a two part process. All the above must be submitted in order for us to evaluate your application. Then, after the application has been approved, you will receive a second form. In order for us to satisfy a licensing requirement, you must be re-evaluated within the 30 day period immediately preceding your actual arrival at the Home. At that time, your doctor must complete and sign the second medical form. This second form is less extensive and does not require additional tests, except for a tuberculin skin test, which must be done within the 30 day period.



**ELKS NATIONAL HOME**  
BENEVOLENT AND PROTECTIVE ORDER OF ELKS  
931 Ashland Avenue  
Bedford, Virginia 24523



**APPLICATION**  
for admission to the National Home  
of the Benevolent and Protective Order of Elks of the United States of America

Name: \_\_\_\_\_ Social Security No. \_\_\_\_\_

Lodge \_\_\_\_\_ No. \_\_\_\_\_ Membership No. \_\_\_\_\_

Membership history: Years in current lodge \_\_\_\_\_ **Attach a copy of your current membership card**

Total years in the Order \_\_\_\_\_

List any other lodges where you have been a member with dates of membership in each:

\_\_\_\_\_  
\_\_\_\_\_

1. Were you ever suspended or expelled from the Order? If so, state when, from what Lodge, and why \_\_\_\_\_

2. Have you ever made application to the Home before? If so, when and with what result? \_\_\_\_\_

3. Are you able to attend to your daily wants without assistance? \_\_\_\_\_

4. Age \_\_\_\_\_ Place of birth \_\_\_\_\_ Date of birth: \_\_\_\_\_

5. Mother's full maiden name \_\_\_\_\_ Living? \_\_\_\_\_

6. Father's full name \_\_\_\_\_ Living? \_\_\_\_\_

7. Married \_\_\_\_\_ Single \_\_\_\_\_ Widowed \_\_\_\_\_ Divorced \_\_\_\_\_

Give full maiden name of spouse \_\_\_\_\_

If spouse is living, give age and address \_\_\_\_\_

\_\_\_\_\_

IX. How many children do you have? \_\_\_\_\_ State name, age, sex, address, and telephone number of each child:

Name	Age	Sex	Address	Telephone
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Attach additional sheet if necessary

9. With whom do you reside? \_\_\_\_\_

10. What is the relationship? \_\_\_\_\_

11. Name, address and telephone number of power of attorney, legal guardian, committee, personal representative, or other person responsible (designate whether power of attorney, guardian, etc.) \_\_\_\_\_

12. Two next of kin:

Name	Relationship	Address	Telephone
------	--------------	---------	-----------

_____	_____	_____	_____
_____	_____	_____	_____

13. Name, address, and telephone number of personal physician \_\_\_\_\_

\_\_\_\_\_

14. Name and address of personal dentist \_\_\_\_\_

\_\_\_\_\_

15. Past occupation/s \_\_\_\_\_

16. Hobbies and special interests \_\_\_\_\_

17. Do you have a will? \_\_\_\_\_ Location of original \_\_\_\_\_

18. Do you have a living will and/or health care power of attorney? \_\_\_\_\_

(If accepted as a resident, you are requested to place a copy of your will, living will and health care power of attorney in your file in our office.)

IX. Have you served in the armed forces of the United States? \_\_\_\_\_ If so, what branch? \_\_\_\_\_

Dates of service (from) \_\_\_\_\_ (to) \_\_\_\_\_ Serial No. \_\_\_\_\_

(If admitted to the Home, bring your discharge papers or a copy)

IX. What are your wishes regarding funeral and burial? \_\_\_\_\_

Place of services \_\_\_\_\_ Place of burial \_\_\_\_\_

Person to contact \_\_\_\_\_

IX. Religion \_\_\_\_\_ Place of worship \_\_\_\_\_

Name, address, and telephone number of clergyman \_\_\_\_\_

\_\_\_\_\_

22. The Department of Social Services, the licensing agency of the Commonwealth of Virginia, requires that the Elks National Home enter into a written residency agreement with each resident at or prior to admission to the Home. Do you acknowledge that you have reviewed that agreement with the understanding that it will take effect upon your admission to the Home? \_\_\_\_\_

IX. \_\_\_\_\_

Applicant's Signature

Address \_\_\_\_\_

Last Permanent Home Address \_\_\_\_\_

IE. *My check for the \$100 Application Processing Fee, payable to the Elks National Home, is enclosed*

**MEDICAL DOCTOR'S CERTIFICATE OF EXAMINATION**  
FOR APPLICATION FOR ADMISSION TO THE ELKS NATIONAL HOME

PLEASE BE SURE ALL QUESTIONS ARE ANSWERED AND ALL REQUIRED REPORTS AND TEST RESULTS ATTACHED.

**COPIES OF THE FOLLOWING ARE REQUIRED:**

CHEST X-RAY REPORT

EKG

BLOOD WORK REPORT (CBC, CHEM. PROFILE, T4)

URINALYSIS

**MEDICAL DOCTOR'S CERTIFICATE OF EXAMINATION**  
FOR APPLICATION FOR ADMISSION TO THE ELKS NATIONAL HOME

**IT IS IMPORTANT THAT ALL QUESTIONS BE ANSWERED  
AN APPLICANT WHO IS A HOSPITAL CASE, CANNOT BE ACCEPTED AS A RESIDENT OF THE ELKS  
NATIONAL HOME. A RETIREMENT COMMUNITY THAT OFFERS ASSISTED LIVING CARE IS NOT  
LICENSED TO PROVIDE NURSING OR CONVALESCENT CARE, NOR IS IT A MEDICAL FACILITY.**

**RELEASE OF CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, authorize the release to the Elks National Home of all medical information requested in relation to my application for residency.

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

*Please attach a copy of chest x-ray report, EKG, blood work report (CBC, hem.. profile, T4), urinalysis*

Applicant's name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Telephone \_\_\_\_\_

Lodge \_\_\_\_\_ Sex \_\_\_\_\_

Date of examination \_\_\_\_\_

I.E. Present \_\_\_\_\_

Illnesses: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

II. Medical History: A. Medications \_\_\_\_\_  
\_\_\_\_\_

B. Allergies/Sensitivities \_\_\_\_\_  
\_\_\_\_\_

C. Diet \_\_\_\_\_

D. Diagnoses or significant problems \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I.E. Hospitalizations – include dates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I.E. Surgeries – include dates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I.E. Injuries – include dates \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

H. Immunizations (give date): Tetanus \_\_\_\_\_ Hepatitis B \_\_\_\_\_  
Influenza \_\_\_\_\_ Pneumovax \_\_\_\_\_

- I. Mental Illness/dementia/hospitalizations \_\_\_\_\_
- J. Cancer \_\_\_\_\_
- III. Social History:
  - A. Tobacco use \_\_\_\_\_
  - B. Alcohol use – quantity/frequency \_\_\_\_\_
  - C. Drug addiction \_\_\_\_\_
  - D. Impairments:
    - 1. Mobility \_\_\_\_\_ Cane? \_\_\_\_\_ Walker? \_\_\_\_\_
    - 2. Hearing \_\_\_\_\_
    - 3. Vision \_\_\_\_\_
    - 4. Bowel/Bladder continence \_\_\_\_\_
    - 5. Confused/Dementia \_\_\_\_\_
  - E. Behavioral problems, specifically any history of aggressive behavior or dangerously agitated states \_\_\_\_\_
  - F. Can the applicant walk up and down stairs on a regular basis? \_\_\_\_\_
    - b) Walk half a mile? \_\_\_\_\_ c) Dress unassisted? \_\_\_\_\_
    - d) Eat without assistance? \_\_\_\_\_ e) Bathe unassisted: \_\_\_\_\_

- IV. Review of Systems:
  - GI \_\_\_\_\_
  - GU \_\_\_\_\_
  - Musculoskeletal \_\_\_\_\_
  - Neurologic \_\_\_\_\_
  - Cardiovascular \_\_\_\_\_

IX. Physical Exam:

Vital Signs: P \_\_\_\_\_ R \_\_\_\_\_ BP \_\_\_\_\_ T \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

General

HEENT: Dentures? \_\_\_\_\_; Upper \_\_\_\_\_; Lower \_\_\_\_\_; Partial \_\_\_\_\_

Lungs: \_\_\_\_\_

Cardiovascular: \_\_\_\_\_

Abdomen: \_\_\_\_\_

Extremities: \_\_\_\_\_

Neurologic: \_\_\_\_\_

Rectal/GU: \_\_\_\_\_

a) Prostate hypertrophy? \_\_\_\_\_

b) Pap done? \_\_\_\_\_ Breast exam: \_\_\_\_\_

Diabetes \_\_\_\_\_ Medication \_\_\_\_\_ Amount \_\_\_\_\_

Thyroid \_\_\_\_\_

Visual Acuity: w/o correction R \_\_\_\_\_ L \_\_\_\_\_

with correction R \_\_\_\_\_ L \_\_\_\_\_

cataracts? \_\_\_\_\_ glaucoma? \_\_\_\_\_

Hearing: with aide? R \_\_\_\_\_ L \_\_\_\_\_

IE. Laboratory – **REQUIRED**

A. Urinalysis: Protein \_\_\_\_\_ Glucose \_\_\_\_\_ Microscopic \_\_\_\_\_

B. Hematocrit/hemoglobin \_\_\_\_\_

(Attach lab reports for all the above)

VII. Is the applicant now:

a) a hospital case \_\_\_\_\_ recently discharged from a hospital \_\_\_\_\_

b) living in a nursing home \_\_\_\_\_ recently discharged from a nursing home \_\_\_\_\_

c) living in an adult group home \_\_\_\_\_ recently discharged from an adult home \_\_\_\_\_

VIII. In your opinion:

a) Does this individual need nursing home and convalescent care? \_\_\_\_\_

b) Is this individual bedfast (confined or restricted to bed for prolonged or indefinite periods?) \_\_\_\_\_

c) Is this person capable of administering his own medicine? \_\_\_\_\_

If assistance is needed, specify type \_\_\_\_\_

d) Is he handicapped: (deaf, blind, etc.) or in any way unable to attend to his ADL's? \_\_\_\_\_

IE. Can this person's needs be met in an assisted living facility? \_\_\_\_\_

IX. Summary of general physical condition: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I certify that this examination was made by me, and that the answers are true and correct to the best of my knowledge and belief. I have re-examined the above certificate and all questions have been answered.

I am a licensed, practicing physician in the State of \_\_\_\_\_, graduate of \_\_\_\_\_

\_\_\_\_\_ Medical School in \_\_\_\_\_ Date: \_\_\_\_\_

Name of physician: \_\_\_\_\_ Date: \_\_\_\_\_

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

\_\_\_\_\_

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

please print or type

Signature

**PHYSICIAN – PLEASE NOTE  
ALL QUESTIONS MUST BE ANSWERED AND REQUESTED REPORTS INCLUDED**

**ELKS NATIONAL HOME  
BEDFORD, VIRGINIA  
CONFIDENTIAL FINANCIAL STATEMENT**

*The information in this financial statement will be kept strictly confidential and will remain in the files at the Elks National Home. Return this directly to the ENH. It does not have to be reviewed by your lodge, unless you are applying on a partial -maintenance application.*

DATE: \_\_\_\_\_

NAME OF APPLICANT: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_ AGE: \_\_\_\_\_

**PART I - DATA**

1. Social Security Number: \_\_\_\_\_

2. Do you have insurance coverage under Medicare? Part A - Yes \_\_\_\_\_ No \_\_\_\_\_

Part B - Yes \_\_\_\_\_ No \_\_\_\_\_

3. Do you have a supplemental health insurance policy? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, please complete the following:

Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

*\*\*Please see note on page 3 regarding health insurance coverage.*

4. Do you have a life insurance policy on your life? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, complete the following:

<i>Insurance Company</i>	<i>Beneficiary</i>	<i>Type</i>	<i>Amount</i>	<i>Surrender Value</i>
--------------------------	--------------------	-------------	---------------	------------------------

5. Do you have a bank trust department or other person manage your financial affairs? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, complete the following:

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

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

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

6. Does an attorney, bank or relative hold Power of Attorney for you? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, complete the following:

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

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

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

NOTE: Before final acceptance as a permanent resident, you will be required to: (1) name a power of attorney  
(2) have a will

## PART II - SOURCES OF INCOME - AMOUNT RECEIVED PER MONTH

	Monthly Amount
1. Social Security _____	_____
2. Pension/Annuity (please identify) _____	_____
3. Interest and Dividends _____	_____
4. Other Income (please identify) _____	_____
<b>TOTAL</b>	=====

Is there an expiration date on any of the above? \_\_\_\_\_

## PART III - ASSETS

*(In the case of a couple, who have joint assets and liabilities, only one applicant must complete Part III and Part IV)*

	Financial Institution	Amount
1. Checking account	(1) _____	_____
	(2) _____	_____
2. Savings account	(1) _____	_____
	(2) _____	_____
3. Certificates	(1) _____	_____
	(2) _____	_____
	(3) _____	_____
4. Other Investment accounts	(1) _____	_____
	(2) _____	_____
	(3) _____	_____
5. Real estate owned - estimated current market value _____		
6. Stocks, bonds, investments - estimated current market value _____		
7. Other assets (specify)	(1) _____	_____
	(2) _____	_____
	(3) _____	_____
<b>TOTAL ASSETS</b>		=====

Please enclose documentation of your cash assets and investments. This may be a summary from your financial institution or your latest account statements.

## PART IV - LIABILITIES

1. Liabilities (specify)	(1) _____	_____
	(2) _____	_____
<b>TOTAL LIABILITIES</b>		=====

**PART V – PRESERVATION OF ASSETS**

1. Have you executed or agreed to execute any deed or deeds of conveyance, or other transfer, to anyone of any property, real or personal? \_\_\_\_\_ If so, when and to whom, and for what consideration? \_\_\_\_\_  
\_\_\_\_\_
2. Have you entered into any agreement either verbal or written, with any person, your Lodge or other organized bodies in connection with this application or affecting your residence at the Elks National Home, other than the agreements contained in this application? \_\_\_\_\_ If you have, state the details \_\_\_\_\_  
\_\_\_\_\_
3. It shall be a condition of your residency at the Elks National Home that you represent that you have not made any gift of real or personal property in contemplation of the execution of your agreement with the Home and you agree that you will make no such gift subsequent to that execution which would impair your ability or the ability of your estate to satisfy your financial obligations. Do you understand and agree to this? \_\_\_\_\_

**APPLICANT SIGNATURE AND INFORMATION RELEASE**

I certify that the information furnished to the Elks National Home in this financial statement is true, correct and complete and hereby give the Elks National Home consent to verify any of the information. Should further financial information become necessary, I authorize the Elks National Home or their agent to conduct a complete financial survey in addition to the statement herewith presented.

If I become unable to handle my financial affairs, it is my wish and direction to my power of attorney that he/she keep all my obligations to the Elks National Home paid to the full extent my income and assets allow.

I understand that this financial statement is primarily designed to enable the Elks National Home to determine my ability to meet the financial requirements of residence at the Elks National Home.

I agree upon acceptance of my application for residency to deposit with the Elks National Home the amount required for the payment plan and type of residency I have chosen. If I shall leave the Home or die while a resident, then all funds remaining in my accounts with the Home, after the payment of all sums due the Home for all expenses and costs expended or incurred on my behalf and after other authorized payments, shall be distributed in accordance with my agreement with the Home.

Date: \_\_\_\_\_ Signature of Applicant \_\_\_\_\_

\*\*\*\*\*

If this statement was prepared by a person other than the applicant, please give:

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

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

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

<p><b>PLEASE NOTE</b></p> <p>If your health insurance coverage is through an HMO, be aware that you will have to enroll in Medicare and possibly secure a supplemental insurance policy. This should be taken care of prior to your arrival at the Home in order to avoid any lapse in coverage.</p>
--