



WESTMINSTER VILLAGE

LICENSED ASSISTED LIVING & MEMORY CARE

Application for Residency

Floor Plan Preference(s) (Select all that apply):

Assisted Living: Studio 1 Bedroom 2 Bedroom

Memory Care: Single Unit Double Unit

Additional Apartment Preferences: _____

Anticipated Move-in Timeline: As soon as possible 6-12 months 1-2 years 3+ years Other _____

Applicant: _____ Last Name First Middle

Second Applicant: _____ Last Name First Middle

Address: _____ Street City State Zip

Home Phone: (____) _____ - _____ Cell Phone: (____) _____ - _____

Email(s): _____

Date of Birth: _____ / _____ / _____ Applicant one Applicant two

Name of Physician: Dr. _____ Phone: (____) _____ - _____

Physicians Address: _____ Address City State Zip

Contact Person: _____ Name (____) _____ Phone No.

Email: _____

By signing this form, the person or persons named above are applying for residency to Westminster Villlage Licensed Assisted Living or Memory Care. Applicant(s) are also consenting to the release of medical information and have agreed to provide the necessary information and forms for residency.

To be completed by Westminster Village

- Physician Report form returned
 Other required paperwork returned
 Resident Assessment completed

Approved for residency by

Date

Date

Signature

Date

Signature