CORVALLIS CARING PLACE ASSISTED LIVING

Application for Residency

Desired Move-In-Date: ______________________ Apt. Type: ____Studio ____ One Bedroom

Name: ______________________________________ S.S. #: _________________ Medicare. #: ________________
(optional)

Age: _______ Birth date: ___________ Marital Status: S M W D

2nd Applicant Name: ________________________ S.S. #: _________________ Medicare. #: ________________
(if applicable) (optional)

Age: _______ Birth date: ___________

Address: ____

City, State, Zip: ____

Phone: ____Email: ____

FINANCIAL INFORMATION: (This information may need to be verified)

Average Monthly Income:___________________________________

Assets to Draw Upon:_______________________________________

Other Resources:____

Medicaid #:____
(optional)

CONTACT FOR FURTHER INFORMATION

Name: ____________________________________ Relationship: ___________________________

Address___________________________________ City/State: _____________________________

Home Phone: ______________________________ Other Phone: ___________________________

Email: ____

_______________________________________ _______________________________________
Applicant's Signature Date

Corvallis Caring Place checks the National and/or State of Oregon sexual offender websites to determine if applicant(s) is registered as a sexual offender or as a sexually violent predator.

Please send completed applications to: **Corvallis Caring Place**
750 NW 23rd Street
Corvallis, Oregon 97330

For office use only:
Date application received: ________