



CORVALLIS CARING PLACE
ASSISTED LIVING
Apartment Application

Desired Move-In Date: _____ Apt. #: _____ (if selected)
Legal Name: _____ Preferred Name: _____
Address: _____ City, State, Zip: _____
Phone: _____ Email: _____
Birthdate: _____ Applicant Relation Status: _____
If you ever lived outside the state, list states: _____
2nd Occupant's Name: _____ 2nd Occupant's Birthdate: _____
Apartment style desired (check one): Studio One Bedroom

FINANCIAL INFORMATION: (This information may need to be verified to meet residency requirements.)

Average Monthly Income: _____ Medicare #: _____
Assets to Draw Upon: _____ Medicaid #: _____
Other Resources: _____ Other: _____

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

CONTACT INFORMATION:

Name: _____ Relationship: _____
Address: _____ City, State, Zip: _____
Phone: _____ Email: _____

Applicant or Authorized Signature

Date

Mail application to: Corvallis Caring Place
750 NW 23rd Street
Corvallis OR 97330

Email application to: info@corvallicaringplace.org

OFFICE USE ONLY: Registry Check: _____

Date application received: _____