



**VFW RETIREMENT HOME, INC.**

13005 N.E. 135<sup>th</sup> Street Fort McCoy, Florida 32134  
Ph: 352-236-0823 Fax: 352-236-2493  
Website: www.vfwretirementhome.flvfw.org

**Resident Application**

A \$250.00 Room Deposit, which can be Pro-rated, must accompany a completed Application for Residency if Estimated Date of Arrival is within 60 Days (pending room availability).

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

DOB: \_\_\_\_\_ Male  Female  Social Security # or last four: \_\_\_\_\_

Telephone No: \_\_\_\_\_ Alternate No: \_\_\_\_\_

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

Type of Room Desired: Couple: \_\_\_\_\_ Private: \_\_\_\_\_ Shared: \_\_\_\_\_

Branch of Service or Affiliation: \_\_\_\_\_ VFW Member: Yes \_\_\_ No \_\_\_

Proof/Sources of Income: \_\_\_\_\_ Date of Arrival: \_\_\_\_\_

Doctor: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

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

Current Diagnosis and/or Medical Problems: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ (Relationship) \_\_\_\_\_

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

Contact Number: \_\_\_\_\_

What are your Funeral/Pre-Needs Arrangements: \_\_\_\_\_

Details: \_\_\_\_\_

Do you have a Last Will & Testament: Yes \_\_\_ No \_\_\_

Where is it located? \_\_\_\_\_

Who is Your Executor or Representative? \_\_\_\_\_

Tell us about yourself: \_\_\_\_\_

Current Cost as of December 2011: Couples: \$1,615.00 per month  
Private Room/Single: \$ 1,415.00 per month Shared Room: \$ 807.50 per month

Please include with your Application some form of documentation of overseas service (your discharge and DD214) and a copy of your VFW, Ladies or Men's Auxiliary Membership Card, if available.

VFW Member \_\_\_\_\_ LAVFW \_\_\_\_\_ Mens Auxiliary \_\_\_\_\_



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### RESIDENT FACE SHEET

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

DOB: \_\_\_\_\_ Male  Female  Married  Single  Widowed

Telephone No: \_\_\_\_\_ Alternate No: \_\_\_\_\_

Social Security # or last four: \_\_\_\_\_

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

Male \_\_\_\_ Female \_\_\_\_ Height: \_\_\_\_ Weight: \_\_\_\_ Hair: \_\_\_\_ Eyes: \_\_\_\_

Doctor: \_\_\_\_\_

Phone #: \_\_\_\_\_ Fax #: \_\_\_\_\_

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

Current Diagnosis and/or Medical Problems: \_\_\_\_\_

Medications: (attach sheet if needed) \_\_\_\_\_

Allergies: \_\_\_\_\_

Medical Implants: \_\_\_\_\_

Next of Kin: \_\_\_\_\_ (Relationship) \_\_\_\_\_

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

Contact Number: \_\_\_\_\_

Authorization for Release of Information: Having no P.O.A. or next of kin to speak on my behalf, I \_\_\_\_\_, currently residing at the VFW Retirement Home, Inc., 13005 NE 135<sup>th</sup> St, Fort McCoy, FL 32134, do hereby authorize the *release of necessary information* regarding my medical conditions and/or concerns to be discussed with the Director or his duly appointed representative regarding any physical or medical conditions, etc that would affect my residency to remain/return to the facility, which is an independent living, non-medical facility.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

VFW Retirement Home Resident

Signed: \_\_\_\_\_ Date: \_\_\_\_\_

VFW Retirement Home Director/Appointed Representative