PC(USA) WAITING LIST APPLICATION

Of

_____

(Applicant)

And

_____

(Spouse*)

For Admission to Residence at

MONTE VISTA GROVE HOMES
THE GROVE CAMPUS, LLC and EXTENDED CARE FACILITIES

2889 San Pasqual Street
Pasadena, CA 91107
Phone: (626) 796-6135
FAX: (626) 796-9753
www.mvgh.org

A senior community with Independent Living accommodations primarily for Teaching Elders (Ministers), Missionaries, Certified Christian Educators, Certified Musician Associates, and Commissioned Ruling Elders of the PC(U.S.A.), and / or their spouses*

A Regional Ministry of the Synod of Southern California and Hawaii

Member of LeadingAge California

**"Spouse" is defined as the person to whom a qualifying individual is legally married or is registered as a State of California Registered Domestic Partner (DP) at the time of admission to MVGH.*

REV. 10/19

PERSONAL INFORMATION

Full Name of Applicant: (Rev./Dr./Mr./Mrs./Miss/Ms.):_____

Current Address:_____

City:_____ State:_____ Zip:_____ Email: _____

Telephone Number(s): Home: (_____)_____ Work: (____)_____ Cell: (____)_____

Social Security #: _____ Date of Birth: _____

Marital Status: Single: _____ Married: _____ Date of Marriage or Certificate of DP: _____

Widowed: _____ Separated:_____ Divorced:_____ Remarried:_____

Ordination Date:_____ in the Presbytery of:_____

Current Presbytery:_____

Denomination/Board/Agency/Primarily Served:_____

SPOUSE/PARTNER:

Full Name of Spouse/Partner: (Rev./Dr./Mr./Mrs./Miss/Ms.):_____

Email:_____

Telephone Number(s): Work: (_____)_____ Cell: (_____)_____

Social Security #: _____ Date of Birth: _____

IF APPLICABLE:

Ordination Date:_____ in the Presbytery of:_____

Current Presbytery:_____

Denomination/Board/Agency/Primarily Served:_____

EMERGENCY INFORMATION

Notify:_____ Relationship:_____

Address:_____

Telephone Number(s): Home: (_____)_____ Work: (____)_____ Cell: (____)_____

ADDITIONAL INFORMATION

Do you have Traditional Medicare? Yes ☐ No ☐

Do you have the Board of Pensions Medicare Supplement? Yes ☐ No ☐

Do you have Long Term Care Insurance? Yes ☐ No ☐

What year would you like to move to MVGH?_____

How did you learn about MVGH? Were you referred by a resident? If so, who?

I/We have received and reviewed the **MVGH Application for Residency Information**. I/We understand that applicants are offered residency based on approval and availability and that as such, I/We cannot be guaranteed housing. I/We understand that this application is not complete unless accompanied by the required **Service Record**. I/We agree to comply with all requests for financial and medical information. I/We agree to conform to any amendments, modifications or changes that the MVGH Board of Trustees may hereafter deem necessary. I/We will keep MVGH informed of my/our current address and advise MVGH of any changes in employment, health and/or marital status. I/We attest that information provided is true and correct. I/We understand that the withholding or falsification of information may result in the disqualification of my/our application the forfeit of my/our application fee.

APPLICANT:	SPOUSE/PARTNER:
_____	_____
(PRINTED NAME)	(PRINTED NAME)
_____	_____
(SIGNATURE)	(SIGNATURE)
_____	_____
(DATE)	(DATE)

Information provided is kept confidential. All application materials become the property of MVGH.

For Office Use Only:

DATE APPLICATION RECEIVED:_____ BY:_____

APPLICATION FEE RECEIVED:_____ (Y/N OR WAIVED)

DATE APPROVED BY RESIDENT RELATIONS:_____

DATE APPROVED BY MVGH BOARD OF TRUSTEES:_____

WAITING LIST AND DATE:

PRIMARY ACTIVE:_____ PRIMARY INACTIVE:_____ SECONDARY:_____ EXCEPTION: _____