



## The Gregory Wing at St. Andrews Village

The Gregory Wing is the program that inspired our expansion into other levels of care, and our compassionate commitment to seniors and their families is just one of the reasons the Gregory Wing feels like home.

### *State-of-the-art, completely personalized care.*



Patient-focused, always. Our medical, nursing and rehabilitative team is always listening to what our residents and their families need and want. Our personalized wellness plan guides the care we provide every single day. Whether you choose private or semi-private accommodations, our VA-certified, restorative nursing care puts your needs first and provides the best possible outcomes.

### *An engaging and inviting environment.*

Warm and bright. The Gregory Wing at St. Andrews Village offers spacious rooms with airy, 9' ceilings and large, sunny windows. Our residents love the expansive views and easy access to our Community Garden's walking paths. Delicious and nutritious dining choices, engaging activities and opportunities to socialize also help residents feel at home.



### *Staying connected to families.*

We're listening to you. Residents and their families have strong voices in how services are provided at the Gregory Wing. We actively seek your feedback through planning meetings, activities and family council, and attentively and respectfully respond to your requests. We know how much you wish you could be here to help, and we will always treat you—and your loved ones—like family.





## **Gregory Wing (Long Term Care)** **Services and Fees** *(Effective October 2025)*

The Gregory Wing at St. Andrews Village provides individualized, quality long term care to residents in need of support services 24 hours a day. Our personal care is planned to precisely fit the needs of every resident. We immediately reassure residents and families that they are in good hands, in a loving environment.

A close-knit community of private and semi-private suites are clustered around inviting common areas that promote relaxation. The Gregory Wing offers spacious rooms with airy, 9-foot ceilings and large, sunny windows. Our residents love the expansive views and easy access to the gardens and walking paths. Delicious/nutritious meals, engaging activities and opportunities to socialize—all provided to make residents feel right at home.

### **SERVICES**

#### **Comprehensive services included in the fee:**

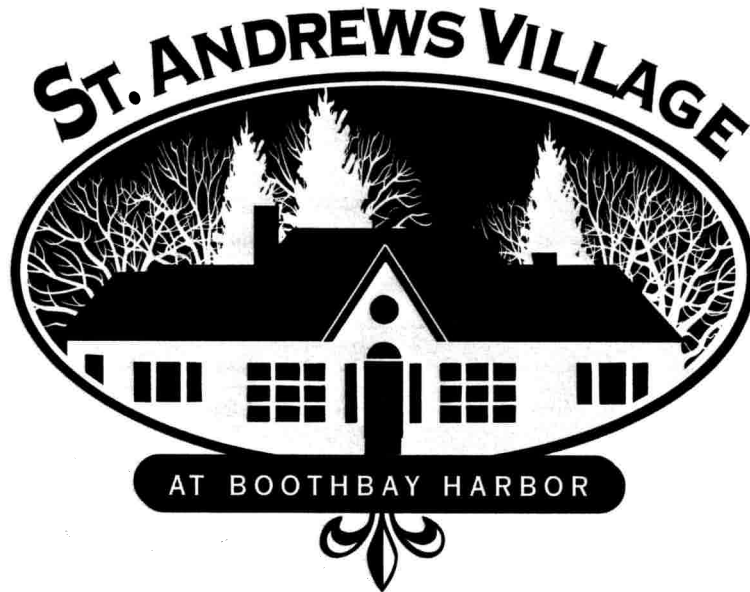
- ✓ Skilled 24-hour nursing care
- ✓ Administering medications
- ✓ Assistance with activities of daily living (bathing, dressing, eating, etc.)
- ✓ Nutritious meals and snacks to meet resident needs
- ✓ Stimulating activities for the mind and body
- ✓ Transferring (moving to and from a bed or a chair)
- ✓ Care for incontinence
- ✓ Personal laundry, linens and housekeeping
- ✓ Scheduling and transportation for medical appointments
- ✓ Social services
- ✓ Managing pain
- ✓ Preventing wandering and unsafe behavior
- ✓ Rehabilitation

#### **FEES (effective October 2025):**

Nursing Care – Semi-Private Room	\$500 per day
Nursing Care – Private Room	\$583 per day
Skilled – Semi-Private Room	\$577 per day
Skilled – Private Room	\$619 per day

APPLICANT'S NAME \_\_\_\_\_

DATE \_\_\_\_\_



*The Caring Choice  
for Families Like Yours*

APPLICATION FOR RESIDENCE AND RESIDENT PROFILE

PLEASE CHECK ALL THAT APPLY:

ASSISTED LIVING \_\_\_\_\_

GREGORY WING NURSING HOME \_\_\_\_\_

SAFE HAVENS \_\_\_\_\_

**IDENTIFICATION SUMMARY (CONFIDENTIAL)**

*Applicant Name:* Last First MI Sex Religion

*Usual Residence:* Street Home Phone Birthdate Age

City/Town State County Zip Code Marital Status Is spouse living?

Social Security Number Place of Birth Citizen of what county?

Spouse's Name Address Phone Number

**HEALTHCARE PROVIDERS**

Attending Physician Address Phone #

Alternate Physician Address Phone #

Dentist Address Phone #

Eye Doctor/Optomtrist Address Phone #

**INSURANCE INFORMATION**

Responsible Party Address Phone # Relationship

METHOD OF PAYMENT:  Private  Medicaid If Medicaid, has an application been made?  Yes  No  
I.D. #

Medicare # BC/BS Number and Coverage

Other/Secondary Insurance Name

**ADVANCE DIRECTIVES**

Do you have a LIVING WILL? Healthcare Proxy? Healthcare Power of Attorney?

**MILITARY HISTORY**

Have you served in the U.S. Armed Forces? Unknown Branch Dates of Service

**OTHER**

Church or Synagogue Address Phone #

Funeral Home to Notify Address Phone #

Education Level (circle one) 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 Other Occupation

Referred By/How did you hear about St. Andrew's Village?

**MEDICAL SUMMARY**

Primary Diagnosis: \_\_\_\_\_

Secondary Diagnosis: \_\_\_\_\_

Allergies: \_\_\_\_\_ Current Medications: \_\_\_\_\_

Additional Space if Needed \_\_\_\_\_

**PREVIOUS HOSPITAL ADMISSIONS**

Admission Date \_\_\_\_\_ Discharge Date \_\_\_\_\_ Facility \_\_\_\_\_ Reason for Admission \_\_\_\_\_

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Admission Date \_\_\_\_\_ Discharge Date \_\_\_\_\_ Facility \_\_\_\_\_ Reason for Admission \_\_\_\_\_

**PREVIOUS LONG TERM CARE ADMISSIONS**

Name and address of doctors and/or specialists Applicant has seen during the past two years. Please list all medical doctors, eye specialists, speech therapists, oral surgeons, podiatrists, psychiatric stays and rehab stays.

NAME/ADDRESS

SPECIALITY

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

**PLEASE ARRANGE TO HAVE ONE OF THE FOLLOWING SENT TO US: Hospital Discharge Summary or Recent Medical Examination.**

**FAMILY SUPPORT FACILITIES**

Please list name, address and telephone number of family members, significant others, etc.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Name, address and telephone numbers of children.

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

What is the Applicant's primary language? \_\_\_\_\_

Does the Applicant speak any other languages? \_\_\_\_\_

Is the Applicant a registered voter? \_\_\_\_\_ Will he/she wish to vote? \_\_\_\_\_

Upon whom does the Applicant rely on most?

Name

Address

In the event of a doctor's appointment, who should be contacted for transportation of Applicant?

1. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

2. Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Present Living Arrangements and Care Requirements:

In home     Apartment     Boarding Home/Assisted Living     Hospital     Friends/Relatives

Other: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

INDIVIDUAL CHARACTERISTICS

Type of diet while at home? \_\_\_\_\_

List any food allergies: \_\_\_\_\_

Food/Likes: \_\_\_\_\_

Food/Dislikes: \_\_\_\_\_

What is the Applicant's usual retiring time? \_\_\_\_\_

How long does the Applicant usually sleep? \_\_\_\_\_

Does Applicant take naps during the day? \_\_\_\_\_

Does the Applicant awaken during the night? \_\_\_\_\_ What generally helps promote sleep? \_\_\_\_\_

Does the Applicant appear confused during the night? \_\_\_\_\_

Does Applicant have difficulty with:

- Speech, Feeding, Toilet, Hearing, Ambulation, Bowel, Dressing, Bathing, Bladder, Other. Includes checkboxes and usual patterns for bowel and bladder.

Are there any behavior concerns? Yes No Explain \_\_\_\_\_

THIS IS A NON-SMOKING FACILITY

Use of alcoholic beverages? Yes No Any history of alcohol abuse? Yes No

History of Mental Illness? Yes No History of Mental Retardation Yes No

What has Applicant been told about placement? \_\_\_\_\_

What was the Applicant's reaction? \_\_\_\_\_

What was the Applicant's reaction to the facility? \_\_\_\_\_

What has the Applicant been told about his/her diagnosis and/prognosis? \_\_\_\_\_

What was the reaction? \_\_\_\_\_

Who or what was the most influential in making the final decision in seeking placement? \_\_\_\_\_

Has the Applicant used any community resources or agencies while living at home? Yes No

If yes, please explain \_\_\_\_\_

Does the Applicant prefer being alone or group activities? \_\_\_\_\_

Applicant's hobbies and/or interests? \_\_\_\_\_

Name of clubs & organizations to which the Applicant belongs or has belonged to in the past? \_\_\_\_\_

DISCHARGE PLAN:

Do you consider this long-term or temporary placement? \_\_\_\_\_

All residents have discharge planning initiated on admission, taking into account the resident's individual care needs & prognosis. In the event the Applicant improves significantly to be discharged, have any tentative plans been made for living arrangements? Yes No

Who will be involved in the planning? \_\_\_\_\_

Estimated length of stay at St. Andrews Village? \_\_\_\_\_

Applicant's Signature

Informant's Signature

Relationship to Applicant

Date



Please complete this form as best as possible and drop-off or mail to  
 Attn: Rose Huntington, Business Office.

## Financial & Medical Expenses Information

*Please complete both sides.*

### **APPLICANT(S) INFORMATION**

**Applicant (1)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

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

Phone #: (     ) \_\_\_\_\_ Email: \_\_\_\_\_

**Applicant (2)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Social Security No. \_\_\_\_\_

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

Phone #: (     ) \_\_\_\_\_ Email: \_\_\_\_\_

**Contact Person** (if different from above) Name: \_\_\_\_\_ Phone: (     ) \_\_\_\_\_

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

### **INCOME**

<b>Income</b>	<b>Applicant (1)</b>	<b>Applicant (2)</b>	<b>Total/Month</b>	<b>Total/Year</b>
Social Security	\$ _____	\$ _____	\$ _____	\$ _____
SSI/Disability	\$ _____	\$ _____	\$ _____	\$ _____
Pensions	\$ _____	\$ _____	\$ _____	\$ _____

**Is your pension adjusted periodically for cost-of-living increases?**

Yes     No

<b>Income</b>	<b>Applicant (1)</b>	<b>Applicant (2)</b>	<b>Total/Month</b>	<b>Total/Year</b>
Annuities	\$ _____	\$ _____	\$ _____	\$ _____
Wages	\$ _____	\$ _____	\$ _____	\$ _____
Interest/Dividends	\$ _____	\$ _____	\$ _____	\$ _____
Other Income	\$ _____	\$ _____	\$ _____	\$ _____

**Do you receive any financial assistance from your family?**

Yes     No    If "Yes", please indicate the amount and frequency of assistance:

Amount \$ \_\_\_\_\_ Frequency \_\_\_\_\_

(OVER)

*(continued)*

**ASSETS:** Please provide the total value of the assets listed:

	<b>Applicant (1)</b>	<b>Applicant (2)</b>	<b>Total</b>
<u>Bank Accounts:</u>			
Savings	\$ _____	\$ _____	\$ _____
Checking	\$ _____	\$ _____	\$ _____
Certificates	\$ _____	\$ _____	\$ _____

	<b>Applicant (1)</b>	<b>Applicant (2)</b>	<b>Total</b>
<u>Investments:</u>			
Stocks	\$ _____	\$ _____	\$ _____
Bonds	\$ _____	\$ _____	\$ _____
Trust Funds	\$ _____	\$ _____	\$ _____
Property	\$ _____	\$ _____	\$ _____

	<b>Applicant (1)</b>	<b>Applicant (2)</b>	<b>Total</b>
<u>Real Estate:</u>			
Est. Home Value	\$ _____	\$ _____	\$ _____

**MEDICAL EXPENSES**

	<b>Applicant (1)</b>	<b>Applicant (2)</b>	<b>Total/Month</b>	<b>Total/Year</b>
Medical Insurance	\$ _____	\$ _____	\$ _____	\$ _____
Medical Bills	\$ _____	\$ _____	\$ _____	\$ _____
Prescriptions	\$ _____	\$ _____	\$ _____	\$ _____
Physician Fees	\$ _____	\$ _____	\$ _____	\$ _____
Dental Expenses	\$ _____	\$ _____	\$ _____	\$ _____
Hospital Expenses	\$ _____	\$ _____	\$ _____	\$ _____
Other Expenses	\$ _____	\$ _____	\$ _____	\$ _____

**Do you have Long-Term Care Insurance?**

Yes     No

**APPLICANT(S) AFFIDAVIT**

To the best of my knowledge, all the information on this application is complete and accurate. I understand this information will be kept confidential and will be used only for the purpose of determining eligibility for residence and suitability of the unit.

Signature of Applicant (1) \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Applicant (2) \_\_\_\_\_ Date: \_\_\_\_\_