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 respectively 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 2026)

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:

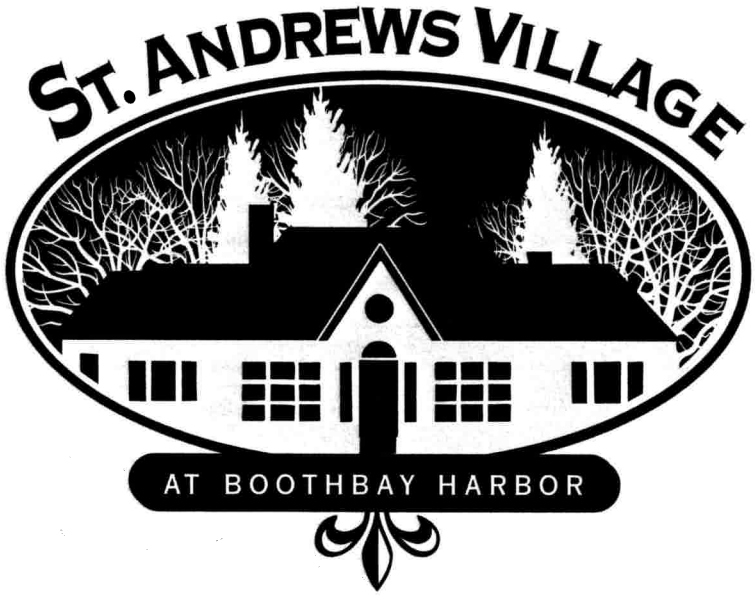
- ✓ Skilled 24-hour nursing care
- ✓ Administering medications
- ✓ Assistance with activities of daily living (bathing, dressing, eating, etc.)
- ✓ Nutritious meals and snacks to meet resident needs
- ✓ Stimulating activities for the mind and body
- ✓ Transferring (moving to and from a bed or a chair)
- ✓ 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 2026):

Nursing Care – Semi-Private Room	$525 per day
Nursing Care – Private Room	$612 per day
Skilled – Semi-Private Room	$606 per day
Skilled – Private Room	$650 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/Optometrist _____ 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 _____

Admission Date _____ Discharge Date _____ Facility _____ Reason for Admission _____

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 - Usual Pattern _____
☐ DRESSING ☐ BATHING ☐ BLADDER - Usual Pattern _____
☐ OTHER, Please Specify: _____

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

Income	**Applicant (1)**	**Applicant (2)**	**Total/Month**	**Total/Year**
Social Security	$_____	$_____	$_____	$_____
SSI/Disability	$_____	$_____	$_____	$_____
Pensions	$_____	$_____	$_____	$_____

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

❑ Yes ❑ No

Income	**Applicant (1)**	**Applicant (2)**	**Total/Month**	**Total/Year**
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:

	Applicant (1)	Applicant (2)	Total
Bank Accounts:			
Savings	$_____	$_____	$_____
Checking	$_____	$_____	$_____
Certificates	$_____	$_____	$_____

	Applicant (1)	Applicant (2)	Total
Investments:			
Stocks	$_____	$_____	$_____
Bonds	$_____	$_____	$_____
Trust Funds	$_____	$_____	$_____
Property	$_____	$_____	$_____

	Applicant (1)	Applicant (2)	Total
Real Estate:			
Est. Home Value	$_____	$_____	$_____

MEDICAL EXPENSES

	Applicant (1)	Applicant (2)	Total/Month	Total/Year
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:_____