Safe Havens Memory Care

at St. Andrews Village

Safe Havens provides a safe, comfortable, and welcoming environment for residents with Alzheimer's or dementia. We provide the resources, services, and support residents need to preserve memory, retain independence and feel right at home.

A close-knit community of private and semi-private suites clustered around inviting common areas, the program at Safe Havens immediately reassures patients and families that they are in good hands. Our professional team works closely with families, physicians, and resident to create personalized wellness plans for each resident.

At the heart of the Alzheimer's Care program is our outdoor garden. In all seasons, the garden provides serenity and solace for patients and their families. The community kitchen reinforces memory with favorite smells, tastes and tasks. A calendar of daily activities provides the comforts of routine as well as feelings of accomplishment, progress and self-worth.

For seniors not yet ready for full-time residency, St. Andrews Village Safe Havens also offers Adult Day Services seven days a week. When caregivers and families need a respite and time to recharge, our dedicated family is here to help.

Safe Havens Memory Care

Rates and What's Included

(Effective October 2026)

Safe Havens memory care at St. Andrews Village is here to help. Safe Havens provides a safe, comfortable and welcoming environment for residents with memory loss. We also provide the resources, services and support seniors need to preserve memory, retain independence and feel right at home.

SERVICES

Comprehensive services included in the monthly fee:

- ✓ Private or Semi-Private Suite
- ✓ Three Meals Served Daily
- ✓ 24-hour Staff Supervision and Safety Checks
- ✓ Housekeeping and Laundry Services
- ✓ Heat and Electricity
- ✓ Bed Linen Service
- ✓ Professional Nursing Assessments and Care Planning
- ✓ On-Site Social Services
- ✓ Personal Care Assistance (based on plan of care)
- ✓ Assistance with Medication Administration
- ✓ Emergency Response Systems
- ✓ Scheduled Local Transportation
- ✓ Social and Recreational Events Coordinated by Activities Staff

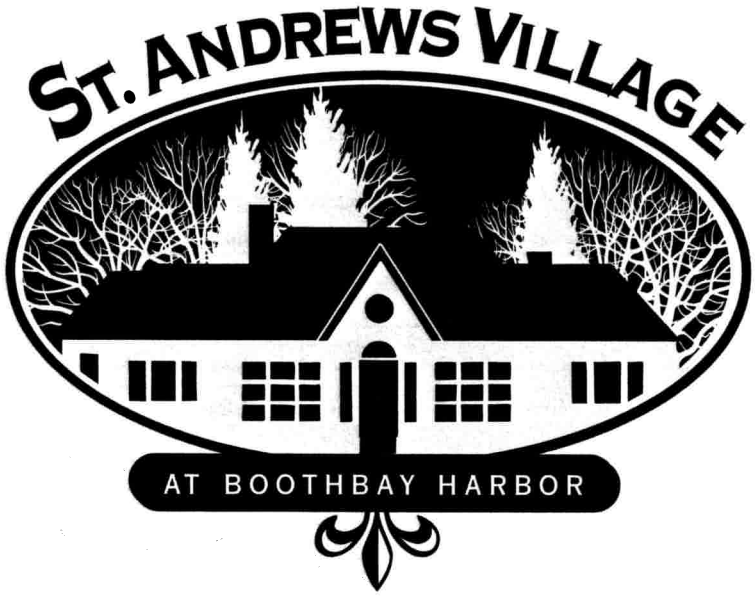
FEES

Fee schedule effective October 2026:

Safe Havens Private Room	Starts at $399 per day	(approx. $11,970/mo)
Safe Havens Semi-Private Room	Starts at $375 per day	(approx. $11,250/mo)
Adult Day Services	$23.00 / hour Mon-Fri	$28.00 / hour Sat-Sun

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:_____