1355 E Street, SE
Washington, DC 20003
(202)543-1778
info@capitolhillvillage.org

# Membership Application Household – Member 1

**Membership Type:** Regular Membership Plus Urgent Subsidized

| **CONTACT & DEMOGRAPHIC INFORMATION:** | |
|---|---|
| **First Name:** | **Last Name:** |
| **Date of Birth** (mm/dd/yyyy): | |
| **Address:** | **Zip:** |
| **Home Phone:**<br>☐ Preferred | **Cell Phone:**<br>☐ Preferred |
| **Email Address:** | **Do you regularly check email:**<br>☐ Yes ☐ No ☐ N/A |
| **How would you like to receive Newsletter/weekly emails:**<br>☐ Email ☐ Paper ☐ Both | |

| **BASIC INFORMATION:** | |
|---|---|
| **Gender Identity:**<br>☐ Female ☐ Male<br>☐ Prefer to Self-Identify<br>_____________<br>☐ Prefer not to answer | **Do you identify as a member of the LGBTQ community?**<br>☐ Yes ☐ No ☐ Prefer not to answer<br>**Pronouns (eg., she/he/they)**<br>____________________ |
| **What is your race/ethnicity (Please select all that apply):**<br>African American/Black Asian Hispanic/Latino/a<br>Euro-American/ White Native American/Pacific Islander<br>Other (Please answer): Prefer not to specify | |
| **Marital Status:** Single Married/Partnered Divorced Widowed<br>Other Prefer not to answer | |
| **Home Style:**<br>Apartment/ Condo Single | **Years you have lived on Capitol Hill:** |

| SPECIAL NEEDS/ HEALTH INFORMATION: | | | | |
|---|---|---|---|---|
| **Special Needs:** Wheelchair Mobility Device Hearing Impaired Low Vision Service Animals Problems with Stairs Use Companion Support | | | | |
| **Home Accessibility Challenges:**<br>Stairs Bathroom Other: | | | **Do you Drive:**<br>Yes No | |
| **Primary Care Doctor:** | | **Insurance:** | | |
| **Hospital in Case of Emergency:** | | | | |
| **Health Care Directives:**<br>☐ Yes ☐ No<br>**Name:** | **Advanced Power of Attorney:**<br>Yes No<br>**Name:** | | | |
| **EMERGENCY CONTACT INFORMATION:** | | | | |
| **First Name:** | **Last Name:** | | | |
| **Relationship to the Applicant:** | **Email Address:** | | | |
| **Address:** | **City/State:** | | | **Zip:** |
| **Phone Number:** | **Do they have a key to the house?**<br>Yes No | | | |

| TELL US A LITTLE MORE ABOUT YOUR SKILLS AND INTERESTS: |
|---|
| |

**What are your primary interests in joining the Village?** (check all that apply)

Make new connections/friends
Preparing for retirement
Attend social, wellness, and educational events
Volunteer opportunities
Network of volunteer helpers
Case management & referral services
Interested in supporting CHV financially

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# Membership Application Household – Member 2

**Membership Type:** Regular Membership Plus Urgent Subsidized

| **CONTACT & DEMOGRAPHIC INFORMATION:** | | |
|---|---|---|
| **First Name:** | **Last Name:** | |
| **Date of Birth** (mm/dd/yyyy): | | |
| **Address:** | | **Zip:** |
| **Home Phone:**<br>☐ Preferred | **Cell Phone:**<br>☐ Preferred | |
| **Email Address:** | **Do you regularly check email:**<br>☐ Yes ☐ No ☐ N/A | |
| **How would you like to receive Newsletter/weekly emails:**<br>☐ Email ☐ Paper ☐ Both | | |

| **BASIC INFORMATION:** | |
|---|---|
| **Gender Identity:**<br>☐ Female ☐ Male<br>☐ Prefer to Self-Identify<br>____________<br>☐ Prefer not to answer | **Do you identify as a member of the LGBTQ community?**<br>☐ Yes ☐ No ☐ Prefer not to answer<br>**Pronouns (eg., she/he/they)**<br>__________________ |
| **What is your race/ethnicity (Please select all that apply):**<br>African American/Black Asian Hispanic/Latino/a<br>Euro-American/ White Native American/Pacific Islander<br>Other (Please answer): Prefer not to specify | |
| **Marital Status:** Single Married/Partnered Divorced Widowed Other Prefer not to answer | |
| **Home Style:**<br>Apartment/ Condo Single | **Years you have lived on Capitol Hill:** |

| SPECIAL NEEDS/ HEALTH INFORMATION: | | | |
|---|---|---|---|
| **Special Needs:** Wheelchair Mobility Device Hearing Impaired Low Vision Service Animals Problems with Stairs Use Companion Support | | | |
| **Home Accessibility Challenges:**<br>Stairs Bathroom Other: | | | **Do you Drive:**<br>Yes No |
| **Primary Care Doctor:** | | **Insurance:** | |
| **Hospital in Case of Emergency:** | | | |
| **Health Care Directives:**<br>☐ Yes ☐ No<br>**Name:** | **Advanced Power of Attorney:**<br>Yes No<br>**Name:** | | |
| **EMERGENCY CONTACT INFORMATION:** | | | |
| **First Name:** | **Last Name:** | | |
| **Relationship to the Applicant:** | **Email Address:** | | |
| **Address:** | **City/State:** | | **Zip:** |
| **Phone Number:** | **Do they have a key to the house?**<br>Yes No | | |

| TELL US A LITTLE MORE ABOUT YOUR SKILLS AND INTERESTS: |
|---|
| |

**What are your primary interests in joining the Village?** (check all that apply)

- Make new connections/friends
- Preparing for retirement
- Attend social, wellness, and educational events
- Volunteer opportunities
- Network of volunteer helpers
- Case management & referral services
- Interested in supporting CHV financially