Dear Applicant,

Attached is the basic admission application and general information regarding services at Inova Loudoun Nursing and Rehabilitation Center (ILNRC).

Please review this information carefully and complete all forms prior to returning them to ILNRC. These forms must be returned to us before we can consider the applicant for an admission.

We will be happy to answer any of your questions by phone or in person. We encourage applicants and family members to visit our facility as part of the application process. You may call for an appointment, Monday through Friday, 8:00 a.m. to 4:30 p.m.

Thank for your interest in our facility.

Sincerely,

Elizabeth P. Kaeser, RN, MSN, LNHA, CPHQ
Administrator, Inova Loudoun Nursing and Rehabilitation Center

T. 703.771.2841 **F.** 703.771.2800
235 Old Waterford Road NW
Leesburg, VA 20176

INOVA LOUDOUN NURSING AND REHABILITATION CENTER
ADMISSION POLICIES AND PROCESS

Inova Loudoun Nursing and Rehabilitation Center is licensed by the Department of Health, Office of Licensure and Certification, and certified to participate both in the Virginia Medical Assistance Program (Medicaid) and in the Medicare program. In addition, the Inova Loudoun Nursing and Rehabilitation Center is accredited by The Joint Commission.

Inova Loudoun Nursing and Rehabilitation Center admits adult residents without regard to race, sex, age, religion or handicap. Admissions will be confined to applicants to whom the Center can safely and adequately provide care and services. Because of our rural setting, priority for admission will be given to Loudoun County residents.

Inova Loudoun Nursing and Rehabilitation Center is a **non-smoking facility**.

The applicant must be admitted by a physician having clinical privileges at Inova Loudoun Nursing and Rehabilitation Center. You are required to contact the physician and have the physician's agreement to follow the applicant through the admission process and thereafter.

Please review the List of Charges (attached) for the cost for room, board and care, including our estimate of extra costs for pharmacy, supplies, etc. Estimate the cost for a six-month period. If it appears that the applicant's resources are not adequate to cover that first six months (180 days), you will need to check with your local Department of Social Services to determine the applicant's eligibility of Virginia Medicaid for nursing home care. If Medicaid will be needed as a payment source within 180 days of admission, a screening/authorization must be done prior to admission. The screening is done to assure the Virginia Medical Assistance Program that the applicant needs nursing home care. For the pre-screening, contact the applicant's local Department of Social Services to get instructions on the eligibility determination. If in the hospital, contact the hospital's discharge planner.

After the applicant's records are reviewed and he/she is accepted for admission, the responsible party and/or applicant will be expected to set up an appointment with the Admissions representative to review and sign the admission papers prior to the expected admission date. Please bring in the applicant's Medicare, Medicaid and insurance cards, Advance Directive (if any), and any document relating to Power of Attorney or legal guardianship. Copies of these will be made for the Center's records.

LIST OF CHARGES EFFECTIVE 1/1/2014

Daily Rates:

Semi-private room	**$315.00 per day**
Private room	**$345.00 per day**
Postacute room/semi-private	**$610.00 per day**
Postacute room/private	**$610.00 per day**

Your daily rate includes the following services, regardless of payment source:

- oversight by a licensed nursing facility administrator
- medical direction by a licensed physician
- twenty-four hour licensed nursing care
- full-time dietary services overseen by a registered dietitian
- ongoing activities program
- medical social services
- incontinence care and management
- in-room telephone service
- housekeeping services
- maintenance services
- linen service for facility linens
- television/cable

If your stay is covered by Medicaid or Medicare, Inova Loudoun Nursing and Rehabilitation Center accepts reimbursement as full payment for these services including approved ancillary charges. Ancillary charges not covered, which include personal laundry and beauty shop and barber services, may be charged to your resident fund account or your responsible party when the service or item is requested by you or your representative.

PRIVATE PAY, MEDICARE AND COMMERCIAL INSURANCE CLIENTS

Unless covered by your insurance company, you may be charged for the following services when they are prescribed, requested and used. We will either bill your carrier directly or assist you in billing your insurance company.

ANCILLARY SERVICES

- personal comfort items, notions and novelties
- cosmetic and grooming items
- beauty and barber shop services
- personal clothing
- personal reading material
- social events and outside entertainment offered outside the scope of the activities program

- specially prepared or alternative foods beyond that routinely prepared by the facility
- transportation
- customized or specialized equipment to carry out medical treatments or care
- drugs and biologicals (billed by Pharmacy)
- specialized physician services and diagnostic studies
- rehabilitative therapies
- personal laundry
- oxygen and related supplies
- guest meals
- bed hold during periods of absence, when desired

During a Skilled stay under Medicare Part A, Days 1-20 are covered in full. For Days 21-100, a co-pay is assessed daily. The co-pay rate is set annually by Medicare.

*** Please note that all Medicare Skilled coverage is subject to meeting Medicare criteria for Skilled services.**

CLIENTS COVERED BY MEDICAID

The following additional services are included as part of your Medicaid benefits and will not be charged to you or your representative:

> Routine personal hygiene items including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps or specialized cleansing agents required to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over-the-counter drugs, hair and nail hygiene services, bathing and basic personal laundry.

The following ancillary services or items may be charged to your resident fund or responsible party when you or your representative requests the services:

- personal comfort items, notions and novelties
- cosmetic and grooming items and services in excess of those identified above
- personal clothing
- personal reading material
- social events and entertainment offered outside the scope of the activities program
- non-covered special care services such as privately hired nurses or aides
- specialized, individualized equipment not covered by Medicaid for nursing facility residents (i.e., certain eyeglasses, customized wheelchairs, routine dental care, etc.)
- private room, except when medically necessary

- specially prepared or alternative food requested instead of the food generally prepared by the facility
- beauty and barber shop services
- guest meals
- bed holding during periods of absence, when desired

YOU WILL BE INFORMED OF THE COST OF EACH SERVICE THAT YOU OR YOUR REPRESENTATIVE REQUESTS TO BE PROVIDED. INOVA LOUDOUN NURSING AND REHABILITATION CENTER WILL MAINTAIN A DETAILED ACCOUNTING OF ALL CHARGES AND DEPOSITS MADE TO YOUR RESIDENT FUND ACCOUNT.

CHARGES WILL BE MADE ONLY FOR SERVICES OR ITEMS REQUESTED AND PROVIDED.

I have read the foregoing and understand that I will be financially responsible for ancillary services and items provided outside the scope of the daily rate for nursing facility services.

_____ Date: _____
Resident/Responsible Party

Inova Loudoun Nursing and Rehabilitation Center

By: _____ Date: _____

Printed name and title: _____

INOVA LOUDOUN NURSING AND REHABILITATION CENTER

Date Received: _____

_____ _____ _____ _____ _____
Applicant's Last Name First Name MI Sex Marital Status

Current Address _____
Birth Date: _____/_____/_____ Birthplace: _____
Previous Occupation_____ Religion_____
Father's Name_____ Mother's Maiden Name_____
Spouse's Name_____

Social Security Number _____/_____/_____

Medicare Number_____ Effective Date_____
Hospital _____Yes _____No Medical _____Yes _____No

Medicaid Number_____
Other Health Insurance _____

NOTIFY IN CASE OF EMERGENCY

First Preference_____ Relationship_____
Home Phone Number _____ Work Phone Number_____

Second Preference_____ Relationship_____
Home Phone Number_____ Work Phone Number _____

GUARANTOR (Responsible Party Who Will Handle Billing and/or Sign Papers)

Guarantor's Name_____ Relationship _____
Address_____
Home Phone Number_____ Work Phone Number_____

PROSPECTIVE RESIDENT COMING FROM (Please Check)

Yes No Home (whose) Name _____
___ ___ Home for Adult Address_____
___ ___ Hospital _____

Date of last hospital admission _____
Date of hospital discharge _____

Referring Physician _____ Phone Number_____

Physician who will treat at LNRC _____ Phone Number_____

Diagnosis 1) _____ 2) _____

Name Address Phone Number
Dentist _____
Podiatrist_____
Opthalmoligist_____
Funeral Home_____

To Medicaid Applicants:

For those Applicants interested in Medicaid funding for a Nursing Facility admission, Medicaid coverage depends on each state's program. In this state, Virginia requires a pre-screening of the applicant's medical and financial needs before an admission. For those determined to be eligible, the Medicaid program will pay for:

- Physician Services
- Personal Hygiene items
- Nursing Services
- Dietary Services
- Activities Program
- Laundry Services
- Room Services (housekeeping, maintenance)

The Department of Social Services will determine what amount of your income you are required to pay for your care. The facility can bill only what the Medicaid program allows. Medicaid permits the resident to keep $40.00 per month for personal use. All of a resident's income, less any medical insurance premiums, is to be used for the cost of care. Medicaid pays the difference between the total due from the Resident and the balance owed to the facility.

It is the resident's or responsible party's responsibility to complete the annual review forms that are mailed from the Department of Social Services. Failure to complete these forms for the resident will result in the denial of Medicaid benefits and possible discharge from the facility.

Residents may have a Resident Trust Fund account opened for them by the Business Office. All funds are deposited in an interest-bearing account. The facility will maintain all records and will provide you with a quarterly statement indicating all transactions and interest payments. This trust fund account is without any cost or charges.

The resident has the right to:

Manage his or her personal funds.
Apply to the Social Security Administration to have a representative payee designated.
Designate in writing to have another person manage the personal fund.

The Medicaid program ***will not*** pay for:

- special request items or services that are in excess or more expensive than what are already provided
- Telephone, television, radio, reading material
- Novelties or candy
- Personal clothing or gifts
- Privately hired medical personnel or services
- Premiums on life insurance or burial policies
- Travel funds to visit home or family

_____ _____
Resident / Responsible Party Date

_____ _____
Witness Date

INOVA LOUDOUN NURSING AND REHABILITATION CENTER
235 OLD WATERFORD ROAD, N.W.
LEESBURG, VA 20176

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

_____
Medical Record Number

Patient's Name _____ ____/____/_____
Birth Date

Address _____ _____
(Include Street, City, State, Zip) Phone Number

The undersigned hereby authorizes and requests Inova Loudoun Nursing and Rehabilitation Center to provide

_____

_____
(Identity of third party or name of any duly authorized representative. Include address [Street, City, State, and Zip]).

with access to my medical records for the purposes of review and examination and further authorizes and requests that you provide such copies thereof as may be requested.

The foregoing is subject to such limitations as indicated below:

( ) Covering records for the period from _____ to _____.
(Date) (Date)

( ) Confined to the following specified information:

_____ Discharge Summary	_____ History & Physical
_____ Lab and X-Ray Findings	_____ Operative Report and Pathology Report
_____ Progress Notes	_____ Emergency Room Record
_____ Outpatient Record	_____ Physician's Orders
_____ Nurses Notes	_____ Other (Please specify): _____

PURPOSE:

____ Medical Follow up	____ Individual Use	____ I will pick up records
____ Attorney	____ Disability	____ Other _____

PATIENT ADVISED OF CHARGES: ___ Yes ____ No ____ N/A

_____ Please mail the records _____ Fax to the number above _____ I will pick up the records

_____ I wish to review the records (**NOTE: You will need to make an appointment for the review.)**

( ) No limitations placed on dates, history of illness, diagnostic and therapeutic information, including any treatment for alcohol and drug abuse. (Signer to initial for authentication of this response.)
_____

I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be redisclosed and is no longer protected by these regulations.

I understand that written notification is necessary to cancel the authorization and can be addressed to the department listed at the top of this form. I am aware that my cancellation will not be effective as to disclosures already made in reference to this authorization.

I understand Inova Health System may not condition treatment on my decision to sign this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure or information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. (Information disclosed regarding treatment for alcohol and/or drug abuse is protected by Federal law. Federal regulations (Title 42 CFR Part 2) prohibit anyone from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations).

I understand that this disclosure may include information regarding drug abuse, alcoholism, or alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Statute (42 CFR Part2).

This consent will automatically expire on _____ or 90 days from the date signed. Furthermore, this consent will be revoked upon compliance of this request and will not serve for any other future request.

_____ _____

Date Signature of Patient

_____ _____

Witness Signature of Legal Representative

_____

Relationship to Patient

PAYMENT AGREEMENT

Guarantee of Payment – Inova Loudoun Nursing and Rehabilitation Center (ILNRC)

For and in consideration of services rendered to the above named patient/resident, while at ILNRC, the undersigned guarantees payment for all charges not covered under the patient/resident's insurance, including deductible and co-pay charges that may be required by your insurance during an insurance covered benefit period.

I agree to pay the full amount due monthly as billed by ILNRC. Invoices will be mailed at the beginning of each month, and are **due in full** upon receipt, **no later than the 15th of the month.** I understand that if I fail to make payments as scheduled ILNRC reserves the right to charge interest on the unpaid balance at the rate of eighteen percent (18%) per annum.

I understand that if it is necessary for ILNRC to secure the services of a collection agency or attorney to collect payment for this account, I agree to pay reasonable collection and attorney's fees.

I will mail payments to: Inova Loudoun Nursing and Rehabilitation Center, Attention: Business Office, 235 Old Waterford Rd. N.W., Leesburg, VA 20176.

SIGNATURE:_____ DATE:_____

PRINTED NAME:_____RELATIONSHIP:_____

ADDRESS: _____

_____

HOME PHONE: _____ WORK / CELL PHONE: _____

_____ _____

Facility Representative Date

PLEASE NOTIFY BUSINESS OFFICE AT 703-771-2842 OF ANY CHANGES IN ADDRESS OR PHONE NUMBER

LAUNDRY POLICY AND AGREEMENT

Laundry service is offered to patients/residents of ILNRC for a fee of $2.75 per day. If the patient/resident elects NOT to have ILNRC do their laundry, and family or friends do not provide clean clothing for them, we reserve the right to do the laundry and bill it to the patient/resident's account.

All clothing must be marked with the patient/resident's name with a laundry marker. Medicaid residents are exempt from the fee for this service.

_____ I request that ILNRC does my laundry for $2.75 per day.

_____ I DO NOT want ILNRC to do my laundry, and will have it done by family or friends.

_____ _____
Resident or Responsible Party Date

_____ _____
Facility Representative Date

INOVA™
Join the future of health.

APPLICATION

Inova Loudoun Nursing and Rehabilitation Center

PERSONAL INFORMATION

Applicant's Full Name _____ Phone Number _____

Address _____ City_____ State ____ Zip _____

Date of Birth _____/_____/_____ Age ____ Sex ____ Social Security No. _____-_____-_____

Marital Status = Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐

Spouse's Name _____ Living ☐ Deceased ☐

Hospital Stay(s) During the Past 6 Months? Yes ☐ No ☐

Name of Hospital(s) _____

Hospital Discharge Date(s) _____/_____/_____ and _____/_____/_____

Have You Been in a Medicare Certified Nursing Home Bed in the Past Year? Yes ☐ No ☐

If Yes, Name of Healthcare Center _____

If Yes, Admission Date _____/_____/_____

RESPONSIBLE PARTY

Full Name _____ Relationship_____

Home Phone _____ Work Phone _____ Cell Phone _____

Power of Attorney? Yes (Provide Copy) ☐ No ☐ **Court Appointed Guardian?** Yes (Provide Copy) ☐ No ☐

Insurance Information

Applicant's Insurance Information:

1. Medicare _____
NAME MEDICARE NUMBER

2. Insurance _____
NAME OF INSURANCE NAME INSURANCE UNDER INSURANCE CARD NO.

3. Insurance _____
NAME OF INSURANCE NAME INSURANCE UNDER INSURANCE CARD NO.

4. Medicaid _____
NAME MEDICAIDE NUMBER

5. LTC Insurance_____
NAME OF INSURANCE NAME INSURANCE UNDER INSURANCE CARD NO.

6. Supplemental Insurance_____
NAME OF INSURANCE NAME INSURANCE UNDER INSURANCE CARD NO.

FINANCIAL RESOURCES

Applicant's Source of Income:	$ Amount					
Retirement/Pension	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Investment Income	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Social Security (SSA)	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Civil Service Annuity	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Veterans	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Supplemental Security Income (SSI)	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Other (specify)	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Other (specify)	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually

Applicant's Assets:	Type/Location	$ Value/Balance			
Real Estate, Specify Type/Location	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly
Real Estate, Specify Type/Location	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly
Personal Property, Specify Type	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly
Personal Property, Specify Type	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly
Bank Accounts:					
Checking	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly
Savings	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly
CD's	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly
IRA	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly
Other bank account	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly
Insurance Policies	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly
Insurance Annuities. (Cash Value)	_____	_____	❑ total value	❑ avg. mo.	❑ avg. qtrly

Specify Type: _____

Burial Fund? ❑ Yes ❑ No Is it irrevocable? ❑ Yes ❑ No

Funeral Home _____

Applicant's Liabilities	$ Amount					
Rent	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Credit Cards	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Insurance Premiums	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Mortgage, Primary	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Mortgage, Secondary	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Alimony	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Other (specify)	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually
Other (specify)	_____	❑ daily	❑ weekly	❑ bi-weekly	❑ monthly	❑ annually

DECLARATION OF CONFIRMATION

I/We hereby confirm that all information stated in this document is current and correct to the best of my/our knowledge and no requested information has been withheld or misrepresented. I/We authorize **Inova Loudoun Nursing and Rehabilitation Center** to verify any of the above information. I/We understand that falsification of the stated information may jeopardize admission into the Healthcare Center. All information will be kept confidential by **Inova Loudoun Nursing and Rehabilitation Center** and will not be released without my written permission.

Signature: _____ Date: _____

REQUIRED ADMISSION SUPPLEMENTS

1. Chest X-Ray results or a negative PPD report obtained prior to admission. (Performed within the past thirty (30) days).
2. A current history and physical (performed within the past thirty (30) days) from the applicant's physician.
3. A copy of the applicant's Social Security card, as well as copies of all insurance cards (Medicare, Blue Cross/Blue Shield, Medicaid, etc.)
4. A verification of the Mental Illness/Mental Retardation Screening.
5. A copy of any legal guardianship or current power of attorney and advance directive (living will or durable health care power of attorney) if applicable.

PHYSICIANS WHO HAVE ADMITTING/ATTENDING PRIVILEGES AT INOVA LOUDOUN NURSING AND REHABILITATION CENTER

(AS OF NOVEMBER 2013)

Please be sure to check with your current physician to see whether he/she has privileges at ILNRC.
If he/she does not, you will need to contact a physician who does have privileges.

NAME	ADDRESS
Andrew, John, MD Internal Medicine	224-D Cornwall St., NW., Suite 102 Leesburg, VA 20176 703-777-1146; Fax 703-777-3144
Choudhary, Sarfraz, MD Infectious Disease	44035 Riverside Parkway, Suite 440 Leesburg, VA 20176 703-858-9966; Fax 703-858-9177
Cook, John, MD Internal Med/Geriatrics	224-D Cornwall St., N.W., Suite 102 Leesburg, VA 20176 703-777-1146; Fax 703-777-3144
Esanakula, Swarupa, MD	Dulles Primary Care 19415 Deerfield Avenue, Suite 103 Lansdowne, VA 20176 703-953-2665; Fax 703-297-4368, Cell: 703-955- 2695
Fletcher, Page M., MD Geriatric Psychiatry	224 Cornwall St., N.W. Leesburg, VA 20176 703-779-4020; Fax 703-779-4038
Knudson, William E., Jr, DPM	224 D Cornwall Street, Suite 203 Leesburg, VA 20176 703-777-5830; Fax 703-777-5155
Mancini, Thomas J., MD Internal Medicine	44055 Riverside Parkway, Suite 216 Leesburg, VA 20176 703-858-1395; Fax 703-858-7468
Singh, Karnail, MD Internal Medicine	19415 Deerfield Ave, Suite 115 Leesburg, VA 20176 703-729-2626, Fax 703-729-3141
Swiger, Ralph, DDS Dentistry	211 Gibson St., N.W., Suite 110 Leesburg, VA 20176 703-777-6100; Fax 703-777-6032
Ujevic, Neven A., MD Internal Medicine	44055 Riverside Parkway, Suite 116 Leesburg, VA 20176 703-858-3220; Fax 703-858-3221

NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS	
Alkhayat, Jennifer Walker, NP	Capital Palliative Care Consultants 209 Gibson Street, Suite 202 Leesburg, VA 20176 703-396-6197; Fax 703-779-1372
DeGilio, Lisa, NP	Capital Caring 209 Gibson Street NW, Suite 202 Leesburg, VA 20176
Fuller, Rebecca, NP	Evercare Hospice & Palliative Care Medicine 12018 Sunrise Valley Drive, #400 Reston, VA 20191 571-262-5200; Fax 571-521-7249
Newcomer, Christine A., NP Geriatric nurse practitioner	44045 Riverside Parkway Leesburg, VA 20176
Pelkofski, Kathleen, NP	Loudoun Internal Medicine Associates 44055 Riverside Parkway, Suite 116 Leesburg, VA 20176 703-858-3220; Fax 703-858-3221

Orig. 5/2/97 Revised 11/2013

INOVA LOUDOUN NURSING AND REHABILITATION CENTER

SALON CHARGES
EFFECTIVE JANUARY 2013

Shampoo & Set	$15.00
Shampoo, Cut, Set or Dry	$29.50
Cut and Shampoo	$16.00
Male Cut	$13.00
Permanent	$54.00
Hair Color	$39.00
Shampoo Only	$5.00

Chaplaincy List		
Chaplain Virginia Moore Inova Loudoun Hospital Leesburg, VA 703 858 8034	Pastor Cory Welch, Dr.David Janney, Pastor Kurt Bowman Purcellville Baptist Church Purcellville, VA 540 338 6400	Dr. Chip Corbin Round Hill Baptist Church Round Hill, VA 540 338 7979
Father Francis Peffley St. John's Catholic Church Leesburg, VA 703 777 1317	Charlotte & Senior's Assembly of God Worship Center Leesburg, VA 703 777 5662	Reverend David DeBose Church of the Holy Scripture Hamilton, VA 540 338 4166
Alfonza Carter Salem Baptist Church Great Falls, VA 703 264 5161	Reverend David Barton Heritage Baptist Ashburn, VA 703 729 1554	Loudoun Jewish Congregation Ashburn, VA 703 737 6500
Rev Jacob Baum Guilford Baptist Church Sterling, VA 703 430 6444	Rev Jeffrey Roberts Bethany United Methodist Church Purcellville, VA 540 338 7648	Rev Gary Smith Leesburg Church of the Nazarene Leesburg, VA 703 777 6850
Rev Barbara Wilson First Mount Olive Baptist Church 216 Loudoun Street S.W. Leesburg, VA 703 433 9879	Rev Carey Johnson Capital Caring (hospice) 703 786 7295	Rev George Mink Second Mount Olive Baptist Church PO Box 1257 Purcellville, VA 703 338 9421