



Episcopal
SENIOR LIFE
Communities
Life. Inspired every day.

APPLICATION FOR RESIDENCY

The following is an application for admission to:

(Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Ashley Woods - Assisted Living | <input type="checkbox"/> Pinehurst |
| <input type="checkbox"/> Ashley Woods - Memory Care | <input type="checkbox"/> River Edge Manor |
| <input type="checkbox"/> Beatrice Place | <input type="checkbox"/> Seabury Woods - Assisted Living |
| <input type="checkbox"/> Brentland Woods | <input type="checkbox"/> Seabury Woods - Memory Care |
| <input type="checkbox"/> Ellen's Place | <input type="checkbox"/> Seabury Woods - Patio Homes |
| <input type="checkbox"/> Episcopal Church Home | <input type="checkbox"/> Valley Manor |

I. Resident & Co-Resident Information

Resident: _____

Birth Date: _____

Birth Place: _____

Social Security #: _____

Have you or a spouse ever served in the United States Military? Yes No

United States Citizen? Yes No

If not born in the USA:

Naturalized Citizen: Yes No Date: _____

Permanent Residency Visa: Yes No Date: _____

**If you were not born in the USA, you will need to provide copies of your permanent visa/naturalization papers or green card.*

Marital Status: _____

Religion: _____

Primary Phone

Alternate Phone

Email: _____

Current Address: _____

Co-Resident: _____

Birth Date: _____

Birth Place: _____

Social Security #: _____

Have you or a spouse ever served in the United States Military? Yes No

United States Citizen? Yes No

If not born in the USA:

Naturalized Citizen: Yes No Date: _____

Permanent Residency Visa: Yes No Date: _____

**If you were not born in the USA, you will need to provide copies of your permanent visa/naturalization papers or green card.*

Marital Status: _____

Religion: _____

Primary Phone

Alternate Phone

Email: _____

Current Address: _____

II. Emergency Contact Information

Persons to notify in case of emergency :

1. _____	_____	2. _____	_____
Name	Relationship	Name	Relationship
_____		_____	
Street		Street	
_____		_____	
City/Town	State	City/Town	State
	Zip		Zip
_____		_____	
Primary Phone	Alternate Phone	Primary Phone	Alternate Phone
_____		_____	
Email		Email	

_____	_____
Power of Attorney (if applicable)	POA Address (if not above)
_____	_____
POA City, State, Zip	POA Phone
_____	_____
Health Care Proxy (if applicable)	HCP Address (if not above)
_____	_____
HCP City, State, Zip	HCP Phone

Funeral Home Arrangements (if applicable:)

_____	_____	_____
Funeral Home Name	Address	Telephone Number

III. Health Information

Resident

Physician Name: _____
Physician Address: _____
Physician Phone Number: _____
Medicare Number: _____

Additional Medical Insurance Information:

Carrier: _____
Number: _____

Long Term Care Insurance:

Carrier: _____
Number: _____

Prescription Drug/Medicare Part D Insurance:

Carrier: _____
Number: _____

Co-Resident

Physician Name: _____
Physician Address: _____
Physician Phone Number: _____
Medicare Number: _____

Additional Medical Insurance Information:

Carrier: _____
Number: _____

Long Term Care Insurance:

Carrier: _____
Number: _____

Prescription Drug/Medicare Part D Insurance:

Carrier: _____
Number: _____

IV. Financial Information

ALL APPLICANTS MUST COMPLETE THIS SECTION

Regular Monthly Income:

	<u>Resident / Co-Resident</u>
Social Security	_____ / _____
Pension	_____ / _____
Interest	_____ / _____
Dividends	_____ / _____
Mortgage/Rental Income	_____ / _____
IRA Income	_____ / _____
Trust Income	_____ / _____
Other Monthly Income	_____ / _____
Total Monthly Income	_____ / _____

Capital Assets:

	<u>Resident / Co-Resident</u>
Cash (Checking & Savings)	_____ / _____
CDs, Money Market, etc.	_____ / _____
Stocks and Bonds	_____ / _____
IRAs, Annuities, etc.	_____ / _____
House*	_____ / _____
Other Real Estate*	_____ / _____
Life Insurance	_____ / _____
Trust Fund**	_____ / _____
Other Assets	_____ / _____
Total Assets	_____ / _____

Liabilities:

Home Mortgage	_____ / _____
Loan/Installment	_____ / _____
Other Liabilities	_____ / _____
Total Liabilities	_____ / _____

*Plans for disposition of Home and/or Real Estate:

**When was Trust Fund established? Revocable
or Irrevocable? _____

Has there been a transfer of assets including but not limited to real estate in the past 60 months? Yes No

If yes, please explain and note date(s) of transfer(s) _____

Does resident have Durable Power of Attorney? Yes No

Conservatorship/Legal Guardian? Yes No

Pending Status of any of the above? Yes No

If yes, please explain: _____

Regular Monthly Expenses:

	<u>Resident / Co-Resident</u>
Health Insurance	_____ / _____
Prescriptions	_____ / _____
Telephone	_____ / _____
Food	_____ / _____

	<u>Resident / Co-Resident</u>
Legal/POA/Financial	_____ / _____
Pet Expenses	_____ / _____
Car	_____ / _____
Other Monthly Expenses	_____ / _____
Total Monthly Expenses	_____ / _____

V. Priority Consideration

Priority Consideration is a courtesy offered by Episcopal SeniorLife Communities to all persons accepted into any of our communities including Ashley Woods, Beatrice Place, Brentland Woods, Ellen's Place, Episcopal Church Home/The Center for Rehabilitation, Pinehurst, River Edge Manor, Seabury Woods and Valley Manor. This courtesy guarantees a current resident transfer will be considered prior to any persons not affiliated with the organization. However, this is not a guarantee that an admission will take place. Residents may not be granted admission to affiliated programs in the following circumstances:

- The resident requires a medical service outside of the scope of our care.
- The resident is a danger to themselves or others.
- There is not availability of a room or apartment, when needed.
- The resident has past due payments to the organization.
- The resident did not meet the initial financial admission criteria of three years' worth of private pay funds.
- This Admission Application contained inaccurate information.
- Failure to complete and submit the Annual Financial Review.

If we cannot offer an accommodation within Episcopal SeniorLife Communities, in all cases, we will assist with a safe discharge plan for any resident.

By signing below, you are hereby affirming that you understand all information above and that all of the information is correct and truthful to the best of your knowledge. Your signature below grants your primary care physician permission to provide health care and medical information as acceptable.

_____ Date: _____
Resident/Designated Representative Signature

_____ Date: _____
Co-Resident/Designated Representative Signature

In making admission decisions, Episcopal SeniorLife Communities does not discriminate on the basis of race, creed, color, national origin, handicap, gender, marital status, or sexual preference.