



722 Furnace Hills Pike
Lititz, PA. 17543
717-626-2071

Office Use only: Date application received: _____ Notes: _____ _____ _____
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APPLICATION FOR RESIDENCY

It is the policy of United Zion Retirement Community (UZRC) to consider for residency all persons regardless of race, age, sex, color, national origin, ancestry, religious creed, handicap or disability.

ACCOMMODATIONS DESIRED:

Youngest Applicant

Second Applicant (If applicable)

(Indicate "same" as may apply)

Personal Care _____ Nursing Care _____

Personal Care _____ Nursing Care _____

What would be your ideal timing for future residency? (Month & year) _____

PERSONAL AND FAMILY INFORMATION

Name _____

Address _____

Land Line Phone _____

Cell Phone _____

Email Address _____

Date of Birth _____ Age _____

Date of Birth _____ Age _____

Primary Occupation _____

Year of Retirement _____

Religious Affiliation (Denomination) _____

Name of Congregation _____

City/State _____

Check one:

Single _____ Married _____ Widow(er) _____ Divorced _____ Other _____

Youngest Applicant

Describe special interests or hobbies:

Hospital preference: (Circle one for each applicant)

- LGH Lancaster Regional
- Ephrata Hospital Heart of Lancaster
- Other _____

Physician's Name _____

Group Practice Name _____

Address _____

Phone _____

Hair Color/Eye Color _____

Second Applicant (Indicate "same" as applies)

Describe special interests or hobbies:

Hospital preference:

- LGH Lancaster Regional
- Ephrata Hospital Heart of Lancaster
- Other _____

Physician's Name _____

Group Practice Name _____

Address _____

Phone _____

Hair Color/Eye Color _____

	<u>First Applicant</u>	<u>Second Applicant</u>
Do you have an active living will, advance directive or POLST order?	Yes / No	Yes / No
Are you an organ donor?	Yes / No	Yes / No
Do you have a DNR order (do not resuscitate)?	Yes / No	Yes / No
Do you have a pre-paid funeral reserve?	Yes / No	Yes / No
Value of Reserve \$ _____		Value of Reserve \$ _____
Funeral Director _____		_____
City/State _____		_____

How did you first learn about United Zion Retirement Community?

Who was the person of greatest influence in your decision to apply?

_____ Relationship to you _____

INSURANCE INFORMATION

Youngest Applicant

Second Applicant

Social Security Number _____

Medicare Number _____

Medicare Supplement Insurance, Medicare Advantage Plan or Tricare Insurance:

Insurance Carrier _____

Member # _____

Group # _____

Phone # _____

Long-Term Care Insurance: Yes No

Yes No

Insurance Carrier _____

Member # _____

Group # _____

Phone # _____

Note: In order to receive credit for long-term care coverage, supply a copy of your benefits summary page.

Prescription Drug Insurance:

Carrier Name _____

Member # _____

PACE Card # _____

Have you ever made application for Medicaid or had a level of care assessment by the Office of Aging?

Yes / No Date _____

Yes / No Date _____

To whom should bills to be mailed if other than yourself? _____

Have you consulted with an attorney about financial planning for long-term care needs?

Yes / No If yes, explain:

Vehicle Make & Model _____

Vehicle License Plate # _____

FINANCIAL INFORMATION

(If assets, liabilities, or income are joint, divide equally between applicants or list in one column.)

Youngest Applicant**ASSETS:**

Cash/Checking \$ _____
 Savings/Money Mkt. \$ _____
 CD's \$ _____
 Variable Annuities \$ _____
 Mutual Funds \$ _____
 IRA's \$ _____
 Stocks & Bonds \$ _____
 403(b) / 401K \$ _____
 Home Value \$ _____
 Other Real Estate \$ _____
 Trust Funds \$ _____
 Trust Type: Revocable _____ or Irrevocable _____
 Value of business \$ _____
 Loans to others \$ _____
 Other \$ _____
 TOTAL \$ _____

LIABILITIES:(Principle amounts)

Auto Loan/Lease \$ _____
 Mortgage \$ _____
 Notes Payable \$ _____
 Credit Card Debt \$ _____
 Other Debt \$ _____
 TOTAL \$ _____

INCOME: (monthly)

Social Security \$ _____
 Pensions \$ _____
 Pension Survivor Benefits: Yes/No

Fixed Annuity Inc. \$ _____
 Rental Income \$ _____
 Other Income* \$ _____
 TOTAL \$ _____

Second Applicant**ASSETS:**

Cash/Checking \$ _____
 Savings/Money Mkt. \$ _____
 CD's \$ _____
 Variable Annuities \$ _____
 Mutual Funds \$ _____
 IRA's \$ _____
 Stocks & Bonds \$ _____
 403(b) / 401K \$ _____
 Home Value \$ _____
 Other Real Estate \$ _____
 Trust Funds \$ _____
 Trust Type: Revocable _____ or Irrevocable _____
 Value of business \$ _____
 Loans to others \$ _____
 Other \$ _____
 TOTAL \$ _____

LIABILITIES:(Principle amounts)

Auto Loan/Lease \$ _____
 Mortgage \$ _____
 Notes Payable \$ _____
 Credit Card Debt \$ _____
 Other Debt \$ _____
 TOTAL \$ _____

INCOME: (monthly)

Social Security \$ _____
 Pensions \$ _____
 Pension Survivor Benefits: Yes/No

Fixed Annuity Inc. \$ _____
 Rental Income \$ _____
 Other Income* \$ _____
 TOTAL \$ _____

Address and type of other real estate: _____

Information on Business: _____

*Specify "Other" income: _____

Have you assigned and/or transferred any assets for less than fair market value within the past five years? Yes _____ No _____ If yes, explain: _____

Do you own assets or have income not listed in the above section? Yes / No

If yes, explain: _____

EMERGENCY INFORMATION

Indicate individuals to be notified in the order they are to be contacted:

Name	Address	Phone & Email	Relationship	POA?
		Home Work Email		Yes No
		Home Work Email		Yes No
		Home Work Email		Yes No
		Home Work Email		Yes No
		Home Work Email		Yes No

HEALTH & MEDICAL INSURANCE INFORMATION

List below for each applicant any chronic medical conditions affecting your health.
(Include surgeries, joint replacements and any implanted medical devices):

Youngest Applicant

Second Applicant

List any hospitalizations (inpatient and outpatient) you had within the last 30 days:

List any nursing home admissions within the last 60 days:

Check if you need assistance with any of the following:

Youngest Applicant

Second Applicant

___ Ambulation ___ Dressing
 ___ Bathing ___ Eating
 ___ Toileting ___ Medications
 ___ Grooming ___ Phone Use
 ___ Finances ___ Transportation
 ___ Laundry ___ Special Diet
 ___ Other: _____

___ Ambulation ___ Dressing
 ___ Bathing ___ Eating
 ___ Toileting ___ Medications
 ___ Grooming ___ Phone Use
 ___ Finances ___ Transportation
 ___ Laundry ___ Special Diet
 ___ Other: _____

MENTAL HEALTH HISTORY

Youngest Applicant

Second Applicant

List any treatments (inpatient and outpatient) you had for mental health within the past two years.

<u>Hospital</u>	<u>Date</u>	<u>Reason</u>	<u>Hospital</u>	<u>Date</u>	<u>Reason</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

In order to determine my (our) eligibility for residency, I (we) understand that United Zion Retirement Community (UZRC) will investigate my (our) background and the completeness and accuracy of the information provided above. I (we) certify the information in this application and the supporting documentation I/we provided to be complete and accurate and authorize United Zion Retirement Community to investigate any of the above information for verification. I/we understand that such an investigation may include but is not limited to reviewing and verifying the documents I/we have provided, conducting a search of property value websites (such as Zillow.com) and conducting a search of Sex Offender Registries. I (we) understand any misrepresentation, including financial, insurance and health information, may be considered grounds for refusal of admission or termination of residency thereafter. I (we) understand that UZRC reserves the right to deny admission to anyone found listed on federal and state sex offender websites. The above described verifications and investigations will be used solely to evaluate applicants' eligibility for residency, and will not be used to discriminate on the basis of race, age, sex, color, national origin, ancestry, religious creed, handicap or disability.

I (we) understand that this application is not binding on UZRC or the applicant(s). It simply expresses interest in becoming a resident and is submitted to be placed on file; all information is held in the strictest confidence. I (we) understand that I (we) may be denied residency based on UZRC's findings.

Applicant's Signature _____ Date _____

Second Applicant's Signature _____ Date _____

If someone other than the applicant filled out this application, please include:

Name _____ Relationship _____ Phone _____