

APPLICATION FOR RESIDENCE

MORAVIAN VILLAGE OF BETHLEHEM
BETHLEHEM, PENNSYLVANIA

A Planned Retirement Community



January 2000
Revised March 2008



ADMISSION
Moravian Village of Bethlehem
Congregate Apartments/Cottage Homes
526 Wood Street
Bethlehem, Pennsylvania 18018
Phone (610) 625-4885
Fax (610) 625-4719

A Planned Retirement Community

ADMISSION REQUIREMENTS AND PROCEDURES:

On the date of admission, any individual over 55 (fifty-five) years of age, or in the case of a couple, the head of the household is over 55 (fifty-five) years of age, who is able to function independently, can apply for admission to Moravian Village of Bethlehem for residency in a Cottage or Apartment.

If you are interested in residing at Moravian Village of Bethlehem, you must submit a completed application. The application consists of 1) confidential general information; 2) confidential financial information; and 3) confidential medical evaluation.

THE PROCEDURES FOR ADMISSION ARE:

- Schedule a meeting with the Director of Marketing. Discussion will include an approximate date of occupancy, selection of dwelling, options and cost.
- Obtain an application form and submit the three parts: 1) confidential general information; 2) confidential financial information; and 3) confidential medical evaluation. A \$250.00 application processing fee is due when application is made.
- Your application will be promptly reviewed by Moravian Village of Bethlehem.
- You will be notified within (2) calendar days after submission of the application of the status of your application by the Director of Marketing.
- When notified of approval of your application, the Director of Marketing will schedule an appointment with you to sign the Residence and Care Agreement and accept the 10% deposit.
- A settlement date will be scheduled for your move and final payment of 90%, within ninety (90) days.
- For additional information, please call (610) 625-4885, ext. 337.

Who may we contact in case of emergency:

Name: _____ Phone: _____

Name: _____ Phone: _____

Enclosed is my check for \$250.00 which is a non-refundable Application Processing Fee for a

Cottage

Apartment unit at Moravian Village of Bethlehem

Signature: _____

Date: _____

Spouse's Signature: _____

Date: _____



**CONFIDENTIAL
FINANCIAL EVALUATION**

Moravian Village of Bethlehem
Cottage Homes
Congregate Apartments
Bethlehem, Pennsylvania

A Planned Retirement Community

Moravian Village of Bethlehem agrees that this information is confidential and will be used for processing purposes only.

CURRENT MONTHLY INCOME

Salary or Wages	\$ _____	per month
Social Security	\$ _____	per month
Supplemental Security Income (SSI)	\$ _____	per month
Pension	\$ _____	per month
Bond Interest	\$ _____	per month
Interest on Savings and CD's	\$ _____	per month
Stock Dividends	\$ _____	per month
Rental Income/Mortgage Income	\$ _____	per month
Trust Income/Annuity Income	\$ _____	per month
Other	\$ _____	per month
TOTAL REGULAR MONTHLY INCOME	\$ _____	

CAPITAL ASSETS (approximate value)

Real Estate/Land	\$ _____
Cash	\$ _____
Savings Account	\$ _____
Checking Accounts	\$ _____
Certificates of Deposits	\$ _____
Home/Condominium (market value)	\$ _____
Stocks & Bonds (current value)	\$ _____
Other (please describe)	\$ _____
TOTAL ASSETS	\$ _____

MONTHLY OBLIGATIONS AT MORAVIAN VILLAGE OF BETHLEHEM

Medical Insurance	\$ _____	per month
Auto Insurance	\$ _____	per month
Health Care Insurance	\$ _____	per month
Other	\$ _____	per month
TOTAL MONTHLY OBLIGATIONS	\$ _____	

LIFE INSURANCE POLICIES (on applicant's life, or owned by applicant):

	COMPANY	FACE VALUE	CASH VALUE	BENEFICIARY
1.	_____	_____	_____	_____
	_____	_____	_____	_____
2.	_____	_____	_____	_____
	_____	_____	_____	_____

HEALTH INSURANCE POLICIES

COMPANY(S): _____

SUMMARY OF BENEFITS: _____

Your Attorney: _____

Address: _____

Telephone: _____

Power of Attorney: _____ Yes _____ No Type: _____

Held by Whom: _____ Telephone: _____

Address: _____

Do you have a will? _____ Yes _____ No

If so, who is executor/executrix? _____

If someone other than you administers your financial affairs, please provide this person's name, address and phone number: _____

I affirm the foregoing is a true statement of facts known to me and is submitted as part of an application for residence at Moravian Village of Bethlehem.

Signature _____ Date: _____

Signature _____ Date: _____

If prepared by a person other than the applicant, please indicate name, address and phone number below:



526 Wood Street
Bethlehem, PA 18018

Ph: 610-625-4885
Fax: 610-625-4719

Dear Dr.

_____ has applied for residency at Moravian Village of Bethlehem, which is a continuing care retirement community. To support our effort in providing the appropriate level of assistance to your patient, please complete this form in its entirety and return to Moravian Village of Bethlehem at the above address.

Moravian Village of Bethlehem will provide a continuum of care, which will include independent residential living, assisted living, and skilled nursing care. This patient has applied for the independent residential living level of care. To safely live in an apartment or cottage in independent residential living, a resident must be able to perform his or her activities of daily living (ADL's) without assistance from another person and must be socially and psychologically appropriate to live in this setting.

Your prompt completion of this form is very important. Thank you for your assistance. If you have questions regarding the requirements for residential living, please call me at 610-625-4885, x337.

Sincerely,

Director of Marketing

HISTORY AND PHYSICAL SUMMARY

TO BE COMPLETED BY PHYSICIAN

Patient's Name: _____ **Date of Birth:** ____/____/____

Primary and Secondary Diagnoses: _____

Chronic Health Problems and Conditions: _____

Surgical Procedures: _____

Allergies: Foods _____

Allergies: Medications _____

Allergies: Other _____

General Medical Information:

	<u>YES</u>	<u>NO</u>
1. Visual Impairment	<input type="checkbox"/>	<input type="checkbox"/>
a) Glasses	<input type="checkbox"/>	<input type="checkbox"/>
2. Macular Degeneration	<input type="checkbox"/>	<input type="checkbox"/>
3. Hearing Impairment	<input type="checkbox"/>	<input type="checkbox"/>
a) Hearing Aids	<input type="checkbox"/>	<input type="checkbox"/>
4. Speech Impairment	<input type="checkbox"/>	<input type="checkbox"/>
5. Mobility Devices		
a) Cane	<input type="checkbox"/>	<input type="checkbox"/>
b) Walker	<input type="checkbox"/>	<input type="checkbox"/>
c) Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
d) Electric Cart	<input type="checkbox"/>	<input type="checkbox"/>
6. Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
7. Weakness	<input type="checkbox"/>	<input type="checkbox"/>
8. Paralysis	<input type="checkbox"/>	<input type="checkbox"/>
9. Incontinence (Bladder)	<input type="checkbox"/>	<input type="checkbox"/>
10. Incontinence (Bowel)	<input type="checkbox"/>	<input type="checkbox"/>
11. Fall Risk	<input type="checkbox"/>	<input type="checkbox"/>
12. Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>
13. Oxygen	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS: (If “YES” to any of the General Medical Information above, please note # of each and explain)

Mental Status Assessment:

	<u>YES</u>	<u>NO</u>
1. Mental Deterioration	<input type="checkbox"/>	<input type="checkbox"/>
2. Behavior Pattern		
a) Appropriate	<input type="checkbox"/>	<input type="checkbox"/>
b) Wanders	<input type="checkbox"/>	<input type="checkbox"/>
c) Aggressive/Disruptive	<input type="checkbox"/>	<input type="checkbox"/>
3. Orientation		
a) Oriented	<input type="checkbox"/>	<input type="checkbox"/>
b) Disoriented to time, place, or person	<input type="checkbox"/>	<input type="checkbox"/>
4. Aphasia	<input type="checkbox"/>	<input type="checkbox"/>
5. Stroke	<input type="checkbox"/>	<input type="checkbox"/>
6. Depression	<input type="checkbox"/>	<input type="checkbox"/>
7. Psychiatric Diagnosis	<input type="checkbox"/>	<input type="checkbox"/>
8. Hospitalization for Psychiatric Care (if "YES", include date and diagnosis in comments)	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS: (If "YES" to any of above, please note # of each and explain)

Living Skills Assessment:

	<u>WITHOUT ASSISTANCE</u>	<u>NEEDS ASSISTANCE</u>
1. Bathing	<input type="checkbox"/>	<input type="checkbox"/>
2. Dressing	<input type="checkbox"/>	<input type="checkbox"/>
3. Toileting	<input type="checkbox"/>	<input type="checkbox"/>
4. Transferring	<input type="checkbox"/>	<input type="checkbox"/>
5. Eating	<input type="checkbox"/>	<input type="checkbox"/>
6. Mobility	<input type="checkbox"/>	<input type="checkbox"/>
7. Medication Management	<input type="checkbox"/>	<input type="checkbox"/>
8. Housekeeping	<input type="checkbox"/>	<input type="checkbox"/>
9. Bed Making	<input type="checkbox"/>	<input type="checkbox"/>
10. Meal Preparation	<input type="checkbox"/>	<input type="checkbox"/>
11. Laundry	<input type="checkbox"/>	<input type="checkbox"/>
12. Money Management	<input type="checkbox"/>	<input type="checkbox"/>
13. Use of Telephone	<input type="checkbox"/>	<input type="checkbox"/>

COMMENTS: (If "NEEDS ASSISTANCE" to any of above, please note # of each and explain)

Summary of Most Recent Physical Exam: (Include DATE OF EXAM and VITAL SIGNS)

Medications: (Prescription, Over-the-Counter, Remedies)

Dietary Requirements or Restrictions:

Is this person compliant with your suggested Medical Plan of Care? If no, please explain:

Date

Signature of Physician



Address:

Telephone:

MORAVIAN VILLAGE OF BETHLEHEM

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I request that my physician fill out the attached History and Physical Summary on my behalf as part of my application to become a resident at Moravian Village of Bethlehem, a continuing care retirement community.

MEDICAL PRACTICE/PHYSICIAN: _____

PATIENT'S NAME: _____

ADDRESS: _____

DATE OF BIRTH: ____/____/____ SOCIAL SECURITY NO. _____

I, _____, understand that my medical record contains confidential information. If I have discussed certain sensitive information with my personal physician or other provider, my medical record may make reference to this information. The above named medical practice has kept the information in my medical record in strict confidence. I hereby authorize any information from my medical record that is relevant to the questions on the attached History and Physical Summary to be released on that form. I also understand that the above-named medical practice and/or physician cannot be held responsible for how this information is used once it is released.

I hereby authorize release of my medical information for the purpose of filling out the attached History and Physical Summary form to: Moravian Village of Bethlehem, 526 Wood Street, Bethlehem, PA, 18018.

Date

Patient or Representative Signature

Date

Witness Signature

