BETHLEHEM, PENNSYLVANIA

A Continuing Care Community

APPLICATION FOR RESIDENCE

January 2000
Revised March 2023

ADMISSION

Moravian Village of Bethlehem
526 Wood Street
Bethlehem, Pennsylvania 18018
Phone (610) 625-4885
Fax (610) 625-4719

A Continuing Care 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 Suite

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) business 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. 407.

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CONFIDENTIAL GENERAL INFORMATION

A Continuing Care Community

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

APPLICATION FOR RESIDENCE

Applicant Name: ____

Address: ____

Telephone: ____________________________

Email Address:____

Date of Birth: __________________________

Present Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Spouse's Name: ____

Spouse's Date of Birth: _______________ Spouses email address:___________________________

Estate Plan ______ Entrance Fee Plan ______ Modified Entrance Fee Plan _________

MVB Lifecare ______ Yes ______ No

How did you hear of Moravian Village of Bethlehem? _______________________________________

Type of Unit Preferred: ____

Do you plan to bring a car to the village? ____

Do you currently have a Long Term Care Insurance Policy? _____ Yes _____ No

Which Insurance Company? __________

Do you currently: ☐ Rent? ☐ Own a condominium? ☐ Own a house? ☐ Other?

Who may we contact in case of emergency:

Closest Relative(s):

(1) Name: ____ Phone: _________________

Address: ____ Relationship: ______________

(2) Name: ____ Phone: _________________

Address: ____ Relationship: ______________

Name: ____ Phone: __________________

Name: ____ Phone: __________________

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

❑ Cottage ❑ Suite at Moravian Village of Bethlehem

Signature: ____

Date: _________________

Spouse's Signature: ____

Date: ______________

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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 (Medicare & Supplemental)	$ ______________________	per month
Auto Insurance	$ ______________________	per month
Health Care Insurance (LTCI)	$ ______________________	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 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, personal care services, and skilled nursing care. This patient has applied for the **independent** residential living level of care. To safely live in a suite 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, x407.

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:

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

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

____

____

____

____

____

Mental Status Assessment:

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

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

____

____

____

____

____

Living Skills Assessment:

	WITHOUT ASSISTANCE	NEEDS ASSISTANCE
1. Bathing	☐	☐
2. Dressing	☐	☐
3. Toileting	☐	☐
4. Transferring	☐	☐
5. Eating	☐	☐
6. Mobility	☐	☐
7. Medication Management	☐	☐
8. Housekeeping	☐	☐
9. Bed Making	☐	☐
10. Meal Preparation	☐	☐
11. Laundry	☐	☐
12. Money Management	☐	☐
13. Use of Telephone	☐	☐

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: ____________________________________

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