LEGACY PLACE
Cottages

Application for Residency

I. GENERAL INFORMATION

Resident's Name: _____ Date: _____

Street: _____

City: _____

Phone: _____Age: _____ Gender: _____

Date of Birth: _____

Marital Status: Married____ Divorced____Widowed____ Single_____ Separated_____

Are you a U.S. Veteran or is/was your spouse a U.S. Veteran? Yes_____No_____

Social Security# _____ Medicare# _____

Other Supplemental Insurer_____Policy# _____

Medicare Advantage Plan _____Policy# _____

HMO Plan Name _____Policy or ID#_____

Do you have a Prescription Card? Yes_____No_____

If yes, please provide us with a copy of the plan and/or card (both sides) to determine whether it can be honored.

I was referred to you by: _____

Do you have a friend who is a resident here? If so, please provide his/her name:

_____

II. Desired Room:

Personal Care: Please place a check mark next to the room of your choice. If you are willing to accept more than one room, please number them in the order of your preference.

_____ Shared Room (Non-Couple)

_____ Small Studio

_____ Large Studio

_____ Suite

_____ I am married and hope to share my room with my spouse. There is an additional charge per month for a couple. See pricing sheet.

Memory Care: Please place a check mark next to the room of your choice. If you are willing to accept more than one room, please number them in the order of your preference.

_____ Shared

_____ Standard Private

_____ Standard Corner

_____ I am married and hope to share my room with my spouse. There is an additional charge per month for a couple. See pricing sheet.

Please note: Legacy Place will conduct a screening to determine if we are an appropriate placement and whether the prospective resident is suitable for Personal Care or Memory Care.

III. RELIGIOUS INFORMATION

Name of Congregation: _____

Name and phone number of Congregation Secretary: _____

Baptism Date: _____

IV. MEDICAL INFORMATION

Physician's Name: _____ Phone: _____

Street, City, State & Zip: _____

Dentist's Name:_____ Phone: _____

Street, City, State& Zip: _____ Phone: _____

Eye Doctor's Name: _____ Phone: _____

Street, City, State & Zip: _____

Medical Specialist's Name: _____ Phone:_____

Street, City, State & Zip: _____

Hospital Preference: _____ Phone: _____

Street, City, State & Zip: _____

Please describe the applicant's current medical conditions/physical needs?

_____

_____

V. EMERGENCY CONTACTS AND FAMILY MEMBERS

Person to contact in case of emergency:

Name: _____ Relationship: _____

Street, City, State & Zip: _____

Phone: _____ Alternate Phone: _____

Email Address: _____

Alternate person to contact in case of emergency:

Name: _____ Relationship: _____

Street, City, State & Zip: _____

Phone: _____ Alternate Phone: _____

Email Address: _____

VI. POWER OF ATTORNEY

Is someone authorized as a Power of Attorney to handle financial matters and/or make healthcare decisions for the applicant? _____ Yes _____ No

If yes, please provide his/her name and contact information along with a copy of the Power of Attorney.

Name: _____ Relationship: _____

Street, City, State & Zip: _____

Email Address: _____

VII. BILLING INFORMATION

Monthly invoices are to be mailed to the following person:

Name: _____ Relationship: _____

Street, City, State & Zip: _____

Phone: _____ Email Address: _____

VIII. OTHER STEPS AND ITEMS TO COMPLETE

A. **Screening**: Legacy Place Cottages will schedule an appointment to meet with the applicant to assess their current needs. This screening is necessary to determine if Legacy Place is an appropriate placement for the applicant. A fee may be charged to cover travel costs if Legacy Place Cottages staff has to travel over 200 miles to complete the screening.

B. **Medical Evaluation**: Legacy Place Cottages will provide a form that must be completed by the applicant's physician. The form needs to be completed no more than 30 days prior to admission. A copy must be provided to Legacy Place at least two days prior to admission. An additional form is necessary for Memory Care residents.

C. **Insurance Plans and Healthcare Benefits**: Please provide Legacy Place with a copy of the following documents:
   1. Medicare Card
   2. Medicare Supplemental Insurance
   3. Durable Power of Attorney (Blood Card)
   4. Others (PA PACE, Veterans Benefits, Ambulance Service Membership, etc.

IX. Confidential Statement of Financial Assets

The following financial information requested will help us plan for your residency. To protect confidentiality, this information is stored in a locked office and restricted to Legacy Place Cottages management.

1. Monthly Rent for Your Desired Apartment: $_____

2. Present Monthly Earned Income (Do not include dividends or interest income):

Social Security: $ _____

Pension: $ _____

Annuities: $ _____

Veteran's Benefits: $ _____

Other: $ _____

Total: **$** _____

3. Primary Assets Owned by Applicant:

Value of Real Estate: $ _____

Current Value of Stock, Bonds, Savings: $ _____

Face Value of Whole Life Insurance Policy: $ _____

4. Expenses:

Monthly Mortgage, if any: $ _____

Monthly Health Insurance: $ _____

Monthly Prescription Drug Plan: $ _____

Other: $ _____

Total Monthly Expenses: **$** _____

5. When necessary, my resources will be supplemented by a monthly contribution from _____ who is my _____, amounting to $_____ each month.

By affixing my signature below, I certify that the information contained in this application is accurate and complete to the best of my knowledge

_____ Date: _____
Applicant's Signature

_____ Date: _____
Family Member or Power of Attorney Signature (If Applicable)