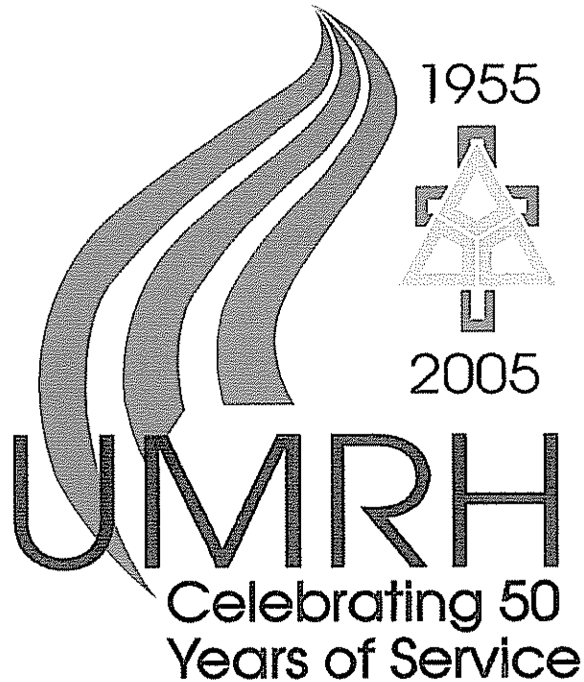
Application For Residency



THE UNITED METHODIST
RETIREMENT HOMES, INCORPORATED
(CROASDAILE VILLAGE AND WESLEY PINES)

The United Methodist Retirement Homes, Incorporated is a non-profit corporation chartered by the State of North Carolina and related by faith to the North Carolina Conference, Southeastern Jurisdiction, of The United Methodist Church

The United Methodist Retirement Homes, Incorporated is an Eagle accredited organization

All our communities offer
Equal Housing Opportunities

INSTRUCTIONS

Thank you for choosing The United Methodist Retirement Homes as your next home. We are pleased to offer two continuing care retirement communities, one located in Durham and the other located in Lumberton. You may choose the one which best fits your particular lifestyle. We are affiliated with the North Carolina Conference, Southeastern Jurisdiction, of The United Methodist Church and invite you to experience "Abundant Living" in a community of caring individuals. Applications are received and processed without regard to race, color, religion, sex, national original or disability.

Please check the community, which you plan to join:

___ **Croasdaile Village**
2600 Croasdaile Farm Parkway
Durham, North Carolina 27705
(919) 384-2000

___ **Wesley Pines**
1000 Wesley Pines Road
Lumberton, North Carolina 28358
(910) 738-9691

* **PLEASE ENCLOSE THE FOLLOWING ITEMS WITH YOUR APPLICATION:**

1. A copy of your last two (2) years Federal Income Tax Returns.
2. Appropriate application fees.
3. Most recent statement from broker or bank verifying your investments (stocks, bonds, CD's, etc.)

* **WHEN COMPLETED, PLEASE SEND THESE TO THE MARKETING DIRECTOR OF THE COMMUNITY YOU HAVE CHOSEN.**

Croasdaile Village
Confidential Data Application

APPLICANT #1	APPLICANT #2
Name: ______________________	**Name:** ______________________
Last *first* *middle*	*Last* *first* *middle*
Address: ______________________	**Address:** ______________________
______________________	______________________
Social Security #: ______-______-______	**Social Security #:** ______-______-______
Telephone #: ______________________	**Telephone #:** ______________________
Date of Birth: ______________________	**Date of Birth:** ______________________

ASSETS

DESCRIPTION	APPLICANT #1	APPLICANT #2	TOTAL/COMBINED
Equity in Residence	$________	$________	$________
Other Real Estate Equity	$________	$________	$________
Savings/CDs	$________	$________	$________
Stocks/Bonds	$________	$________	$________
Mutual Funds	$________	$________	$________
IRA	$________	$________	$________
Trusts	$________	$________	$________
Checking Accounts	$________	$________	$________
Other Assets (Total)	$________	$________	$________

List: ____

____

Total Assets	$________	$________	$________

LIABILITIES

Mortgage on Home/Real Estate	$________	$________	$________
Other Debts (Total)	$________	$________	$________
Total Liabilities	$________	$________	$________

NET WORTH

Total Assets *minus* Total Liabilities	$________	$________	$________

MONTHLY INCOME

Social Security	$__________	$__________	$__________
Pension and Retirement	$__________	$__________	$__________
Interest/Dividend Income	$__________	$__________	$__________
Other Income	$__________	$__________	$__________
Total Monthly Income	$__________	$__________	$__________

List Financial Institutions with whom you have accounts (banks, savings & loan, brokers, etc . . .):

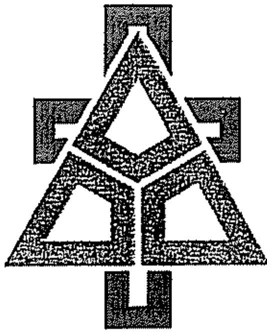
Name:	Mailing Address:	Phone:
__________	__________	__________
__________	__________	__________
__________	__________	__________

MONTHLY EXPENSES

Prescriptions & other medical costs	$__________	$__________	$__________
Meals and utilities that are not included in monthly resident fee	$__________	$__________	$__________
Travel and entertainment	$__________	$__________	$__________
Personal items and clothing	$__________	$__________	$__________
Automobile expenses	$__________	$__________	$__________
Insurance premiums, excluding LTC insurance	$__________	$__________	$__________
Other (describe)	$__________	$__________	$__________
Total Monthly Expenses	$__________	$__________	$__________

I (we) certify that the information given on this Confidential Financial Statement is true and correct and may be relied upon as a basis for admission. I (we) give permission to The United Methodist Retirement Homes, Incorporated to verify the financial information contained in this Confidential Financial Statement for the purpose of processing my (our) Application for Residency. I (we) further authorize The United Methodist Retirement Homes, Incorporated to request additional information concerning my (our) finances.

__________	__________	__________	__________
Date	**Signature Applicant #1**	**Date**	**Signature Applicant #2**



MEDICAL RECORDS
Physician's Report & Examination

The *Physician's Report & Examination Form* is one of the requirements for admission of residency at **Croasdaile Village**, a continuing care retirement community. To be accepted, each resident must be capable of living unit occupancy as defined in the *Admission Policy* of The United Methodist Retirement Homes, Incorporated..

1. Please fill in every item of this form and when the examination is complete, send this form along with laboratory results or other data to: **Croasdaile Village, 2600 Croasdaile Farm Parkway, Durham, NC 27705** to the attention of Director of Marketing.
1. The applicant is responsible to you for the professional fee for this examination.
2. The applicant has signed a *Release of Information* (at the end of this form).

Applicant Information (To be filled out by the prospective resident)

Applicant's Full Name:____

Address:______________________**City:**________________**State:**__________**Zip:**______

Date of Birth:___/___/___ **Age:**_______

Date of Marriage:___/___/___ ☐ **Widowed** ☐ **Divorced** **Date:**___/___/___

Background Information (To be filled out by prospective resident)

*Children:____

____

*Siblings:____

____

*Highest level of education completed:______________________________

*Occupational History:______________________________________

____

____

*Favorite daily activities______________________________________

*Favorite social activities ______________________________________

PHYSICAL EXAMINATION - *(to be filled out by physician)*

Medical History

Regarding the questions below, indicate "yes" or "no" where appropriate. If a descriptive phrase will convey more useful information, please indicate in the space provided.

REGARDING THE APPLICANT:

1. Is he/she on a restricted diet? ☐ **Yes** ☐ **No** ______________________________

2. Has there been any recent change in weight? ☐ **Yes** ☐ **No** ______________________

Diagnosis ____

____

Mental Status

☐ Good Comments ____

☐ Fair ____

☐ Poor ____

Directions N = Normal Ab = Abnormal (Under "Remarks" describe all abnormal findings)

Vital Signs

Temperature ______
Pulse ______
Reg. Pulse ______
Height ______
Weight ______
Blood Pressure ______

General

Nutrition ______
Appearance ______
Skin ______

Ears

Canals ______

Eyes

Conjunctiva ______
Pupils ______
Light Reaction ______
Accommodation ______
Disc ______

Nose

Mucus Membrane ______

Remarks ____

____

Mouth

Teeth ______________
Mucous Memb. ______________
Tonsils ______________

Lungs

Percussion ______________
Breath Sounds ______________
Pharynx ______________

Peripheral Vessels

Posterior Tibia ______________
Dorsalis Pedis ______________

Neck ***Heart*** ***Reflexes***

Thyroid__________________ Sounds______________ Biceps____________________

Veins ___________________ ***Abdomen*** ***Triceps*** ____________________

Lymph Nodes_____________ Liver______________ Abdominal________________

Cervical _________________ Spleen_____________ Knee_____________________

Axillary _________________ Kidneys____________ Ankle_____________________

Inguinal _________________ ***Rectum*** Plantar Response____________

Breasts ***Sphincter*** __________ ***Extremities***

Nipples _________________ ***Prostate***__________ Bones, Joints_______________

Vaginal Pap Smear__________ ***Sensory***

Lungs Vibratory__________________

Persussion _________________

Other______________________

Breath Sounds______________

Remarks____

____

Laboratory (Please give results of any test given during routine physical examinations)
(Number 4 required if applicant is receiving diuretic treatment)

1. Urinalysis:

2. C.B.C.

3. PAP Smear

4. SMA 6 - Electrolytes:

5. SMA 12 (Multiple chemistry screening)

Electrocardiogram: (EKG tracing and report to be submitted as part of this examination)

X-Rays PA & Lateral Chest Report (date given/date read) **and/or** PPD Results (date given/date read) to be submitted as part of this examination. **Mandated by the Center for Disease Control. Resident can not move in until this is submitted.**

Other x-ray if available from prior examination:____________________

GI:____________________

Gall Bladder____________________

Barium Enema____________________

Remarks (on any item above)____________________

____

PHYSICAL EVALUATION

1. Is this person capable of independent living? Yes No
If no, please explain____________________

2. Does this person need assistance with daily living? Yes No
If yes, please explain____________________

3. Does the person have a communicable disease? Yes No
If yes, does the disease pose a significant risk of infecting others? Yes No
If yes, explain____________________

4. Does this person have a pre-existing condition? Yes No
If yes, please explain____________________

5. Is the pre-existing condition stable at this point? Yes No
If yes, please explain____________________

Acceptable for Admission ***(to be filled out by physician)***
The Medical History and Health Examination of ____________________
Has been reviewed and my recommendation is:

Acceptable for Admission Yes No

High level of physical, functional and cognitive independent living skills.

Able to live independently - some concerns exists.

Able to live independently with spouse or another person.

Not able to live independently at the current time

Comments: ____________________

____

____

____

Current Medications: (Please list or attach to Exhibit B)

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

How long has this patient been under your care? ____________

Date of Examination: ____________

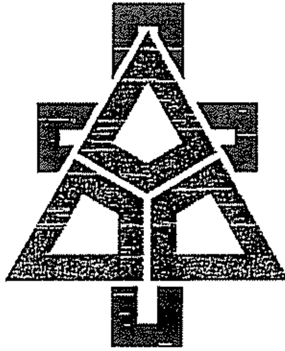
____________________ ____________
Physician Signature Date

____________________ ____________
Address Phone Number

RELEASE OF INFORMATION

I hereby authorize any physician, hospital or clinic to give **Croasdaile Village** any information they request with reference to my medical history, attendance, advice or hospitalization. A photographic copy of this authorization shall be as valid as the original.

____________________ ____________
Applicant Signature Date



CROASDAILE VILLAGE

DETERMINATION OF LIVING UNIT OCCUPANCY

Use a separate form for each applicant.

1. Are you ambulatory to the extent that in case of emergency you would be able to get to safety without assistance? This would not preclude the use of equipment such as a wheelchair, walker, cane, or crutches, if it were possible for you to move unassisted. Yes No
If no, please explain____

____

____

2. Indicate whether you are able or are not able to do the following activities by yourself.

ACTIVITY	CURRENTLY ABLE	CURRENTLY NOT ABLE
Ability to prepare adequate meals independently. Eating without assistance from others. Comments:______________________ ______________________ ______________________	________	________
Ability to do housekeeping independently or with occasional help for heavy work. Comments:______________________ ______________________ ______________________	________	________

ACTIVITY	CURRENTLY ABLE	CURRENTLY NOT ABLE
Ability to ambulate independently or with the assistance of auxiliary aids. Comments:________________________ ____________________________ ____________________________	________	________
Ability to use the toilet without assistance from others. Comments:________________________ ____________________________ ____________________________	________	________
Ability to self-administer medication responsibly and in correct dosages at correct times without assistance from others. Comments:________________________ ____________________________ ____________________________	________	________
Ability to remember date, time, place or person orientation. Comments:________________________ ____________________________ ____________________________	________	________
Ability to fully participate in planning and exercising good judgment in decisions made on matters of personal health and welfare, or ability to participate in planning and decision-making with minor dependence on others.	________	________

ACTIVITY	CURRENTLY ABLE	CURRENTLY NOT ABLE
Aware of and the ability to follow routine safety procedures without assistance from others. Comments:____________________ ____________________ ____________________	________	________
Ability to get own groceries and other items needed for daily living. Comments:____________________ ____________________ ____________________	________	________
Ability to manage own personal and financial matters in a responsible fashion without assistance from others. Comments:____________________ ____________________ ____________________	________	________
Ability to travel independently in a vehicle, or arrange for travel through mass transit or taxi services without assistance from others. Comments:____________________ ____________________ ____________________	________	________
Ability to bathe without assistance from others. Comments:____________________ ____________________ ____________________	________	________

ACTIVITY	CURRENTLY ABLE	CURRENTLY NOT ABLE
Ability to dress appropriately without assistance from others. Comments:______________________ ______________________ ______________________	________	________
Ability to groom hair, nails, body, and clothing without assistance from others. Comments:______________________ ______________________ ______________________	________	________
Ability to communicate independently or with the use of auxiliary aids. Comments:______________________ ______________________ ______________________	________	________
Ability to use and complete a telephone call without the assistance of others. Comments:______________________ ______________________ ______________________	________	________

For those personal needs you are unable to provide for, are you able to arrange for the services necessary to provide for those needs? Yes No . If yes, explain.

____

____

____

____

3. Are you a current illegal abuser or addict of a controlled substance? Yes No
If yes, please explain. ______________________________
____

4. Have you been convicted of the illegal manufacture or distribution of a controlled substance?
Yes No . If yes, please explain. ______________________________
____
____

5. Do you require special modifications to your living unit in order to occupy the living unit?
Yes No . If yes, explain the modifications that would be needed.
____
____
____

Are you willing to make these modifications at your own expense and restore the premises to its original condition? Yes No

6. Is there any reason why your residency would constitute a direct threat to the health or safety of others or would result in substantial physical damage to the property of others?
Yes No . If yes, please explain.
____
____

I hereby declare that all statements made herein are true according to my best knowledge and belief.

I acknowledge that failure to complete this information accurately is grounds for the denial or revocation of living unit occupancy.

______________________________ ______________________________
Witness Applicant

For Your Information...

Medical and Insurance Requirements

1) **Medical Evaluation:**
Prior to entry, you will be asked to submit a Medical Report from your physician on a form provided by Croasdaile Village. An evaluation interview by our staff and/or a physical exam prior to entry is part of our standard admission procedure.

2) **Health/Medical Insurance:**
Residents of all United Methodist Retirement Homes are required to carry Medicare part A and B and supplemental health/major medical insurance. It is advisable to include prescriptions in your insurance coverage.

3) **Long Term Care Insurance Program:**
An excellent program offering long term care insurance is available through UMRH, Inc. Such coverage is strongly recommended, but is not mandatory. The insurance policy offered is not a group policy. The representative who handles this insurance will be glad to meet with you to offer personalized insurance coverage based on your age, health, financial resources and desired benefits. Coverage for home health care and adult care are also available. Your Croasdaile Village Marketing Office will provide additional information regarding this program.

4) **Tenants Insurance**
Coverage to protect your personal property. This coverage is required and insures your personal property against loss. Coverage should also include personal liability coverage and medical payments to others, protecting against injury to others or destruction to others' property.

Please use the Admission Procedure Checklist (on back)
to insure all steps have been completed prior to taking occupancy.

APPLICATION & ADMISSION PROCEDURES

Reservation and Future Residency Application Check List:

_____ Reservation or Future Residency Agreement Signed & Deposit Paid: Date:______
(This reserves your selected home while application is being processed, or subscribes you to the wait list: $1,000 00 is non-refundable) $_________

_____ Application Fee Paid: Date:______
($200.00/Individual; $300 00/Couple, non-refundable, payable when application is submitted. $_________

_____ Application Forms Submitted: Date:______
(to be submitted within 30 days of signing the Residency Agreement)

Admission Procedure Check List:

_____ Notification of Acceptance: Date:______

_____ Residency Agreement: Date:______
(to be signed and a 10% Deposit paid within 10 days of accepting offer on home.) $_________

_____ Medical Form completed and returned by Physician: Date:_____
(to include current 2-Step Mantoux TB, which takes more than two weeks from first test to last to last reading.)
Must be on file before move-in can be set.

_____ Registration Forms: Date:______
(T.V., Cable, Vehicle, Instruction for the Distribution of Property, Pet Registration, Emergency Info., Unit Access, etc.)

_____ Insurance Information: Date:______
(Medicare Part A&B, Supplemental, Long Term Care, Tenant Insurance.)

_____ Custom Options: (100%) Date:______
(any changes or additions made by Croasdaile Village on your behalf) $_________

_____ Balance Due: (90% Balance of Entrance Fee) Date:_____
(when resident is ready to take occupancy, the Admission/Orientation is scheduled with Move-in Coordinator) $_________

_____ Occupancy if prior to move-in: Date:_____
(30—90 days from the signing of your Residency Agreement)

_____ Schedule Move-In: Date:_____
(set date with Move-In Coordinator before it is confirmed with your mover.
All requirements must be met before a date can be scheduled.)

If you have questions regarding the application, the admission procedure or the medical requirements So you can begin planning for your move, please contact your Marketing Counselor at (800)960-7737 Or (919)384-2475.