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INSTITUTE FOR SUCCESSFUL LIVING

Application for Admission

I am interested in:

- ☐ The Carriage Homes
- ☐ Independent Living
- ☐ Personal Care
- ☐ Skilled Nursing Care
- ☐ Rehabilitative Services
- ☐ Alzheimer's & Memory Care
- ☐ Respite Care

Community of Interest: _____

PRIMARY APPLICANT

Name: _____

Title: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____

Email: _____ Phone: _____

SSN: _____ Medicare No.: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Driver's License State & Number: _____

Current Physician: _____ Phone: _____

Physician Address: _____

Hospital Preference: _____

Funeral Home Preference: _____

Funeral Home Address: _____

Attorney: _____ Phone: _____

Attorney Address: _____

Do you have a Living Will?* ☐ Yes ☐ No

Do you have a Durable Power of Attorney (DPOA)?* ☐ Yes ☐ No

**If yes, please provide copies of documentation. DPOA contact information may be provided on page 3.*

VETERAN INFORMATION

Are you a veteran of the armed services? ☐ Yes ☐ No

If yes: Branch: _____ Serial No.: _____

Is your spouse/partner a veteran of the armed services? ☐ Yes ☐ No

If yes: Branch: _____ Serial No.: _____

SECONDARY APPLICANT (IF APPLICABLE)

Name: _____

Title: _____ Date of Birth: _____ Age: _____ Sex: _____

Address: _____

Email: _____ Phone: _____

SSN: _____ Medicare No.: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other: _____

Driver's License State & Number: _____

Current Physician: _____ Phone: _____

Physician Address: _____

Hospital Preference: _____

Funeral Home Preference: _____

Funeral Home Address: _____

Attorney: _____ Phone: _____

Attorney Address: _____

Do you have a Living Will?* ☐ Yes ☐ No

Do you have a Durable Power of Attorney (DPOA)?* ☐ Yes ☐ No

**If yes, please provide copies of documentation. DPOA contact information may be provided on page 3.*

SECONDARY APPLICANT VETERAN INFORMATION (IF APPLICABLE)

Are you a veteran of the armed services? ☐ Yes ☐ No

If yes: Branch: _____ Serial No.: _____

Is your spouse/partner a veteran of the armed services? ☐ Yes ☐ No

If yes: Branch: _____ Serial No.: _____

TRANSPORT PREFERENCES

Are you a member of Millcreek Paramedics? ☐ Yes ☐ No

Are you a member of Emergycare? ☐ Yes ☐ No

Are you a member of Lift? ☐ Yes ☐ No

Are you bringing your own vehicle? ☐ Yes ☐ No

If yes: Make and Model: _____ License Plate Number: _____

PETS

Are you bringing your pet? ☐ Yes ☐ No

If yes, provide details: _____

**please note, some additional information may be required for approval*

EMERGENCY CONTACT(S)

1. _____ Check if Durable Power of Attorney for: ☐ Healthcare ☐ Finances
Name

_____ _____ _____
Relationship *Email* *Phone*

_____
Street Address *City* *State* *ZIP*

2. _____ Check if Durable Power of Attorney for: ☐ Healthcare ☐ Finances
Name

_____ _____ _____
Relationship *Email* *Phone*

_____
Street Address *City* *State* *ZIP*

3. _____ Check if Durable Power of Attorney for: ☐ Healthcare ☐ Finances
Name

_____ _____ _____
Relationship *Email* *Phone*

_____
Street Address *City* *State* *ZIP*

LIFE INSURANCE

Company:_____ Policy No.: _____

Face Value:_____ Cash Surrender:_____

Company:_____ Policy No.: _____

Face Value:_____ Cash Surrender:_____

HEALTH INSURANCE & LONG TERM CARE NURSING HOME INSURANCE

Medicare or Managed Care Plan *(SecurityBlue, Aetna, United Healthcare, etc.)*

_____

Agreement No.:_____ Group No.: _____

Other: _____

Agreement No.:_____ Group No.: _____

Do you have an irrevocable burial account? ☐ Yes ☐ No

FINANCIAL INFORMATION

MONTHLY INCOME

Social Security: _____ Other: _____

Pension: _____

VA Pension: _____ *** _____

(Total Monthly Income)

CHECKING ACCOUNTS

1. _____ _____ _____
Bank/Institution *Joint With* *Balance*

2. _____ _____ _____
Bank/Institution *Joint With* *Balance*

SAVINGS ACCOUNTS/CERTIFICATES OF DEPOSIT

1. _____ _____ _____
Bank/Institution *Joint With* *Balance*

2. _____ _____ _____
Bank/Institution *Joint With* *Balance*

REAL ESTATE

Do you own your own home? ☐Yes ☐No Mortgage Balance: _____

Joint With: _____ Market Value: _____

Other Real Estate: _____ Joint With: _____ Market Value: _____

STOCKS & BONDS

Company: _____ # of Shares: _____ Value: _____

Company: _____ # of Shares: _____ Value: _____

CONSUMER DEBTS/LOANS

Loan/Debt Details: _____ Balance & Monthly Payment: _____

Loan/Debt Details: _____ Balance & Monthly Payment: _____

Loan/Debt Details: _____ Balance & Monthly Payment: _____

CO-GUARANTOR (IF APPLICABLE)

Name: _____ Date of Birth: _____

Address: _____

Email: _____ Phone: _____

SSN: _____ Monthly Income: _____

Occupation: _____ Employer: _____

MENTAL & HEALTH ASSESSMENT

By signing the application below, I understand a medical and health assessment will be preformed by an employed medical professional. I further understand that residency will be contingent upon the assessment.

SIGNATURES

By signing this application, you declare that all of your responses are true, complete, and authorize management of LECOM Institute for Successful Living to verify this information, references, credit records and employment status. Any false statement on this application can lead to the rejection of your application or immediate termination of your residence.

Signature of Applicant:_____ Date: _____

Signature of Secondary Applicant:_____ Date: _____

Signature of Co-Guarantor:_____ Date: _____

REQUIRED DOCUMENTATION FOR APPLICATION

Thank you for your interest in applying to our Communities. To proceed with your application, we kindly request that you provide a copy of your most recent bank statement. This document is essential to ensure we have all the necessary information to complete your application process.

The bank statement should include:

- ☐ Your full name as the account holder
- ☐ Financial Statements
- ☐ A clear transaction history for the relevant period
- ☐ The account balance as of the date of the statement

Please rest assured that all financial information provided will be treated with the utmost confidentiality and used solely for the purpose of assessing your application.

We appreciate your cooperation and look forward to welcoming you to your new home.

FOR INTERNAL USE ONLY

Signature of Approval:_____ Date: _____

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INSTITUTE FOR SUCCESSFUL LIVING

ACKNOWLEDGEMENT & AUTHORIZATION FORM

By signing below, I understand that LECOM Institute for Successful Living obtains a criminal history background check on all admission into their communities.

I hereby authorize and acknowledge that the LECOM Institute for Successful Living may obtain a criminal background check about me.

PRIMARY APPLICANT

Name: _____ Date: _____

SSN: _____ Date of Birth: _____

Signature: _____

SECONDARY APPLICANT (IF APPICABLE)

Name: _____ Date: _____

SSN: _____ Date of Birth: _____

Signature: _____

FOR INTERNAL USE ONLY

Signature of Clearance & Approval: _____ Date: _____

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INSTITUTE FOR SUCCESSFUL LIVING

HIPPA RELEASE OF INFORMATION - PRIMARY APPLICANT

I, _____ , hereby authorize

Resident Name/ Date of Birth

_____ and their staff to release information

Medical Facility

to _____.

LECOM Institute for Successful Living Community

This authorization is valid from the date of this signature. I understand that I have a right to revoke this authorization by providing written notice.

Name of Patient or Responsible Party: _____

Signature of Patient or Responsible Party: _____

Relationship to Patient (If Applicable): _____

Date of Signature: _____

HIPPA RELEASE OF INFORMATION - SECONDARY APPLICANT

I, _____ , hereby authorize

Resident Name/ Date of Birth

_____ and their staff to release information

Medical Facility

to _____.

LECOM Institute for Successful Living Community

This authorization is valid from the date of this signature. I understand that I have a right to revoke this authorization by providing written notice.

Name of Patient or Responsible Party: _____

Signature of Patient or Responsible Party: _____

Relationship to Patient (If Applicable): _____

Date of Signature: _____