United Methodist Communities
Abundant Life for Seniors

APPLICATION FOR ADMISSION

Collingswood

TYPE OF ACCOMODATIONS (Select One)

○ Independent ○ Residential ○ Assisted Living ○ Memory Support ◉ Health Care ○ Respite ○ Hospice

APPLICANT INFORMATION

Last Name	First Name	Middle Initial
Street Address		
City	State	Zip
Phone	Email Address	
Social Security No.	Date of Birth	

Are you (circle one) ○ Single ○ Married ○ Widowed ○ Divorced

SPOUSE INFORMATION

Last Name	First Name	Middle Initial
Social Security No.	Date of Birth	

ALTERNATIVE OR EMERGENCY CONTACT INFORMATION **Please indicate if you are the POA** ○ **Yes** ○ **No**

Last Name	First Name	Middle Initial
Relationship		
Street Address		
City	State	Zip
Phone	Email Address	

LIFE INSURANCE

Company Name	Policy No.
Street Address	Phone

City	State	Zip
Beneficiary	Cash Surrender Value	

LONG TERM CARE INSURANCE

Provider Name	Policy No.
Street Address	Phone

City	State	Zip

Daily benefit amount for the following: Assisted Living _____ Health Care _____

Maximum benefit amount | Is there an elimination period? ○ Yes ○ No How long?

How many activities of daily living (ADLs) are required for insurance activation?

Does your policy have Inflation Protection? ○ Yes ○ No

OTHER INFORMATION

Are you eligible for Veterans Benefits? ○ Yes ○ No

FINANCIAL INFORMATION

MONTHLY INCOME

	Monthly Amount		Company Name and Address	
	1st Person	2nd Person	1st Person	2nd Person
Social Security	$	$		
Pension	$	$	Company Name	Company Name
Is this a joint and survivor pension?	○ Yes ○ No	○ Yes ○ No	Street Address	Street Address
If yes what is the amount of the survivor benefit?	$	$	City, State, Zip	City, State, Zip
Lifetime Annuity	$	$	Company Name	Company Name
Enter Monthly Amt			Street Address	Street Address
			City, State, Zip	City, State, Zip
Other Monthly Income	$	$	Name	Name
			Street Address	Street Address
			City, State, Zip	City, State, Zip
TOTAL INCOME	$ 0	$ 0		

ASSETS

	Amount			
	1st Person	2nd Person	Name and Address of Institute	Account Number
Checking	$	$	Name	Account Number
			Street Address	
			City, State, Zip	
Savings	$	$	Name	Account Number
			Street Address	
			City, State, Zip	
CDs & Money Market Accounts	$	$	Name	Account Number
			Street Address	
			City, State, Zip	
Investments	$	$	Name	Account Number
			Street Address	
			City, State, Zip	
Trust	$	$	Name	Account Number
Is the principal required to be used to pay for the cost of care? ○ Yes ○ No Please attach a copy of the Trust			Street Address	
			City, State, Zip	
Non Lifetime Annuity	$	$	Name	Account Number
Enter total amount			Street Address	
			City, State, Zip	

REAL ESTATE				
	1st Person	2nd Person	1st Person	2nd Person
Property Market Value *	$	$	Property Street Address	Property Street Address
* Provide most recent copy of property tax bill			City, State, Zip	City, State, Zip
Has property been listed? ◯ Yes ◯ No			If yes, name of company:	Phone
Shared Ownership? ◯ Yes ◯ No			Name of co-owner:	
Mortgage or Home Equity Line of Credit	($)	($)	Lender Name	Lender Name
			Street Address	Street Address
			City, State, Zip	City, State, Zip
			Loan Number	Loan Number
TOTAL ASSETS	$ 0	$ 0		

LIABILITIES-exceeding $5,000				
For example: credit cards, auto loans, amounts owed to other entities or individuals.				
	Amount			
Type	1st Person	2nd Person	Name and Address of Institute	Account Number
	($)	($)	Name	Name
			Street Address	Street Address
			City, State, Zip	City, State, Zip
	($)	($)	Name	Name
			Street Address	Street Address
			City, State, Zip	City, State, Zip
TOTAL LIABILITIES	$ 0	$ 0		
TOTAL ASSETS LESS LIABILITIES	$ 0	$ 0		

Please review your records carefully in answering the following question, and list any transfers (for example, gifts of cash or stocks, or transfer of real estate) that you have made in the last five years to any person or entity, including but not limited to your spouse or children. There may come a time during your stay at our community that you make application for Medicaid, and Medicaid will carefully review all bank account and real estate records to determine if there were transfers. As a general rule, Medicaid will penalize the applicant for transfers that were made during a five-year look back period, and will not make payment for care until such time as the penalty period has expired. The fact that you may have made transfers in the past will not automatically disqualify you for admission to our community. The rules and regulations regarding Medicaid are complicated and not all transfers will result in penalty. If Medicaid applies a penalty period for any reason, the applicant is required to pay for care during that penalty period at private pay rates. However, full disclosure is required at this time, and United Methodist Communities will take all necessary legal steps to enforce this obligation.

I, we have transferred assets within the last five years of the date of this application. ◯ **Yes** ◯ **No**

If yes, please indicate the following:

Name of person assets were transferred to:	Amount	Date of transfer

Note: An update of your financial information will be required on an annual basis.

I/we represent that to the best of my/our knowledge the above statements and financial information are true and correct, and that these assets and income are available for the cost of my care and **will not be gifted or transferred**. I/we acknowledge and agree that any false statements made on this application may be grounds for denial of my/our application and/or discharge from the facility.

I also attest that I have not been convicted of or plead guilty to any crime considered a felony, or that I have not been convicted or plead guilty to any crime related to child abuse or sexual abuse, and that I am not presently charged with or under investigation for such charges.

☐ **I/we agree if this is a joint application and one applicant predeceases the other, all of his/her assets shall be transferred to the surviving resident so the assets may be utilized for the cost of care of the surviving resident.**

SIGNATURE OF APPLICANT **DATE**

SIGNATURE OF CO - APPLICANT **DATE**

POWER OF ATTORNEY SIGNATORIES ONLY

I certify that to the best of my knowledge the above statements and financial information are true and correct. I certify that the attached power of attorney is a true copy of the power of attorney provided to me by the Applicant, that it remains in full force and effect, and that I am authorized to execute this document on behalf of the Applicant. I am aware that willfully false statements may be grounds for denial of this application and/or discharge from the facility.

POWER OF ATTORNEY **DATE**

Please return this application to the Sales Office at the community of your choice with the non-refundable processing fee of $100 for individuals or $150 for couples. Make checks payable to United Methodist Communities. There is no charge for an application to healthcare. A financial update will be required for those seeking admission more than three months after the filing of this application.

Date application is complete: _____ Initials:_____