United Church of Christ Homes
FAITH • LOVE • COMPASSION

The Lebanon Valley Home Thornwald Home Ephrata Manor
Sarah A. Todd Memorial Home Kindred Place

APPLICATION FOR ADMISSION

ALL Applicants complete the following pages:

Biographical and Insurance Information: pages 1
Community & Service Interests: page 2
Financial Information: pages 3 and 4
Personal Information: page 6

Nursing and Personal Care Applicants complete additional:

Medical Information: page 5 [unless admitted directly from the hospital or other healthcare facility]

The information requested on these forms is needed to evaluate the applicant for admission. Please complete to the best of your ability. All information will be kept confidential.

Name _____ Date _____

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email Address _____ Social Security Number _____

Date of Birth _____ Sex: Male Female

Marital Status: Single Married Widow/er Divorced Separated

Name of Spouse _____

Insurances: (*Copies of all cards are required)*

Medicare: _____ MBI#: _____

Part A Yes No Part B Yes No

Medical Assistance # _____

Health Insurance Provider _____

Policy # _____

Part D Prescription Drug Provider _____

Policy # _____

Long Term Care Insurance Provider _____

Policy # _____

Admission Application: Community and Service Interests

Is there any special date by which you desire to enter the Community? _____

Check Preferred Location		Check Preferred Accommodation
Ephrata Manor 99 Bethany Road Ephrata, PA 17522 (717) 738-4940		Apartment Personal Care Nursing Care
The Lebanon Valley Home 550 East Main Street Annville, PA 17003 (717) 867-4467		Cottage Personal Care Nursing Care
Thornwald Home 442 Walnut Bottom Road Carlisle, PA 17013 (717) 249-4118		Personal Care Nursing Care
Sarah A. Todd Memorial Home 1000 West South Street Carlisle, PA 17013 (717) 245-2187		Apartment Cottage Nursing Care
Kindred Place at Annville One Kindred Place Annville, PA 17003 (717) 867-5572		Apartment
Kindred Place at Harrisburg 4700 Oakhurst Blvd. Harrisburg, PA 17110 (717) 657-7900		Apartment

With regard to admission and services, it is the policy of United Church of Christ Homes to operate each of its communities and programs, and provide services without discrimination based upon race, color, familial status, religious creed, ancestry, age, sex, gender, sexual orientation, gender identity or expression, national origin, ability to pay, handicap or disability, use of guide or support animals because of the blindness, deafness, or physical handicap of the resident or because the resident is a handler or trainer of support or guide animals.

Admission Application: Financial Information

Applicant Name:_____

Income/Assets Available for Applicants' Care	Applicant	Spouse	*	Not Verified	Explanation
Income					
Monthly Social Security/SSI			*		
Monthly Pensions			*		
Monthly Annuities			*		
Monthly Rental Income			*		
Other (list):			*		
			*		
			*		
Assets Available for Applicants' Care					
Savings & Checking Accounts			*		
Investments			*		
Certificates of Deposit			*		
Home			*		
Other Properties			*		
Automobile					
Life Insurance					
IRA's/Retirement Accounts			*		
Other (list):					
			*		
			*		
Liabilities					
Credit Card Debt			*		
Home Mortgage or Reverse Mortgage			*		
Loans			*		
Notes			*		
Other Debt (list):					
			*		
			*		

*** Please attach verification of requested information.**

Verification of information will be required in order to complete application.

Name of person completing information:_____

Admission Application: Financial Supplement

Applicant Name _____

Do you have a Power of Attorney (POA)? Yes No

If yes, please provide a copy and fill out the following:

Name: _____ Tel # _____

Address: _____ Cell # _____

_____ Email: _____

Do you have a prepaid burial plan? Yes No

If yes, describe _____

Have you sold or transferred any assets for less than fair market value in the past five (5) years?

Yes No

If yes, please describe the asset, the value, and the date of transfer.

_____

_____

_____

Have you purchased a Life Estate in another individual's home? Yes No

If yes, have you lived in that home for at least 1 year? Yes No

In the past five (5) years, have you made any changes to an annuity?

Yes No

If yes, what types of changes did you make? (please check all that apply)

changed the course of payments to be made

changed the treatment of income or principal

added to the principal

made an elective withdrawal of funds

changed the distribution of the annuity

I hereby affirm that the information provided above is true and complete. I understand that any false or misleading representations or omissions may disqualify the applicant for consideration for admission.

By signing below, I hereby give permission to UCC Homes to access my financial information for the purpose of verifying the financial information provided.

Resident/Responsible Party/POA _____ **Date** _____

Note: The facility will complete a background review of assets, including any that may have been transferred or disposed of in the prior five years.

Admission Application: Medical Information

Applicant Name _____

Applicant Information **(Nursing & Personal Care Applicants Only, *unless coming from the hospital or other healthcare facility)***

Are you capable of caring for your personal needs: bathing, dressing, walking, eating? Yes No
If no, please explain:_____

What support and safety measures do you use? Cane Walker Wheelchair
Hearing Aid Glasses

Special Dietary Needs: _____
Allergies:_____

Have you completed a Living Will? Yes No *If Yes, please provide a copy.*

Do you have a POLST? Yes No *If Yes, please provide a copy.*

Do you have an Out of Hospital
DO NOT RESUSCITATE Order? Yes No *If Yes, please provide a copy.*

Signature of person completing information: _____

Physician Evaluation

Height_____Weight _____ BP_____Pulse_____

Is Applicant free of infectious disease? Yes No Date/result last chest x-ray _____

Immunization Hx: Flu _____Pneumovax_____TB_____COVID_____ *(Please provide copy of cards)*

Is Applicant physically restricted in any way?_____

*Is there any history of substance abuse? (i.e. cigarettes, nicotine, alcohol, illegal or RX drugs)
_____

Is there any history of mental illness? If yes, please explain_____

Drug Allergies: _____

	MNL	ABN	Description - Abnormalities
Skin			
Eyes			
ENT			
Lungs			
Heart			
Breast			
Abdomen			
Back			
Genitalia, Rectal			
Extremities			
Neurological			
Orientation, Memory			

Major Diagnoses:

Additional Comments:

Please attach current medications and dosages and any additional information you feel would be helpful in determining Applicant's needs and our ability to meet those needs.

Physician Signature_____ **Date**_____

This question is only asked to have a full understanding of care that may be required and will not be the sole deciding factor when it comes to admissibility.

Admission Application: Personal Information

Applicant Name _____

Names of ALL Living Children: (if none, list three nearest relatives)

RELATIONSHIP	NAME	CITY/STATE	HOME TEL #	WORK TEL#	CELL #

Responsible Party Name _____Home # _____

Address_____Work # _____

_____Cell # _____

E-mail Address_____

1st Emergency Contact_____Home#_____ Work # _____Cell # _____

2nd Emergency Contact _____Home # _____ Work # _____Cell # _____

Veteran Yes No Active duty dates _____ (year) to _____(year)

Spouse of a Veteran Yes No

Additional Information

Church Membership _____City/State_____

Pastor's Name_____Telephone # _____

Religious Denomination_____

Previous Occupation(s)