Office use only: Received: _____

Fairmount

Dedicated to Faith, Family & Community

Application for Residency

APPLICANT #1

For which area of Fairmount are you applying? (You may check more than one.)

Residential Living	Residential Suites	Personal Care	Health Care (Skilled Care)	Rehabilitation
Apartment 1 BR ☐	☐	☐	☐	Private ☐
Apartment 2 BR ☐				Semi-private ☐
Cottage 1 BR ☐				
Cottage 2 BR ☐				

PERSONAL DATA

Name_____E-mail_____

Address _____City, State, Zip _____

Home Phone (____)_____Mobile Phone (____)_____

Date of Birth ____/____/_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Military Veteran: ☐ Yes ☐ No Occupation (prior to retirement) _____

Spouse's Name _____ If deceased, date of death ___/___/____

APPLICANT #2 (IF APPLICABLE)

For which area of Fairmount are you applying? (You may check more than one.)

Residential Living	Residential Suites	Personal Care	Health Care (Skilled Care)	Rehabilitation
Apartment 1 BR ☐	☐	☐	☐	Private ☐
Apartment 2 BR ☐				Semi-private ☐
Cottage 1 BR ☐				
Cottage 2 BR ☐				

PERSONAL DATA

Name_____E-mail_____

Address _____City, State, Zip _____

Home Phone (____)_____Mobile Phone (____)_____

Date of Birth ____/____/_____ Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Military Veteran: ☐ Yes ☐ No Occupation (prior to retirement) _____

Spouse's Name _____

APPLICANT #1

Current Physician _____ Telephone (____)_____ POLST? ☐ Yes ☐ No

INSURANCE INFORMATION (At admission, cards must be presented for verification and copying.)

Medicare Number _____ Social Security Number _____

Supplemental Insurance Company _____Group #_____

Medicare Advantage/PPO _____Group # _____

Medicare Part D or Pharmacy Plan _____ Group # _____

Long Term Care Insurance ☐ Yes ☐ No If yes, Company _____

Life Insurance? ☐ Yes ☐ No Cash Value $_____ Pre-paid burial reserve? ☐ Yes ☐ No

Power of Attorney _____ Relationship _____

Address _____City, State, Zip _____

Telephone (____)_____ Mobile Phone (____)_____ E-mail_____

Type of Power of Attorney: ☐ General ☐ Healthcare ☐ Durable ☐ Bank Living Will? ☐ Yes ☐ No

APPLICANT #2 (IF APPLICABLE)

Current Physician _____ Telephone (____)_____POLST? ☐ Yes ☐ No

INSURANCE INFORMATION (At admission, cards must be presented for verification and copying.)

Medicare Number _____ Social Security Number _____

Supplemental Insurance Company _____Group #_____

Medicare Advantage/PPO _____Group # _____

Medicare Part D or Pharmacy Plan _____ Group # _____

Long Term Care Insurance ☐ Yes ☐ No If yes, Company _____

Life Insurance? ☐ Yes ☐ No Cash Value $_____ Pre-paid burial reserve? ☐ Yes ☐ No

Power of Attorney _____ Relationship _____

Address _____City, State, Zip _____

Telephone (____)_____ Mobile Phone (____)_____ E-mail_____

Type of Power of Attorney: ☐ General ☐ Healthcare ☐ Durable ☐ Bank Living Will? ☐ Yes ☐ No

OPTIONAL INFORMATION

Religious Affiliation _____ Specific Congregation _____

Clergy _____Telephone _____

MEDICAL HISTORY FOR APPLICANT #1

To determine eligibility of insurance benefits and for regulatory compliance, complete the following:

HOSPITALIZATION RECORD

Were you hospitalized in the last year? Yes _____ No _____

Complete the following for any hospitalizations within the last year **or** for the two most recent hospitalizations.

Hospital	Inpatient/ Outpatient	Dates of Hospitalization	Reason
1.			
2.			

Details on any other significant hospitalizations or surgeries:_____

_____

Hospital of choice for future hospitalizations:_____

MENTAL HEALTH RECORD

Have you ever received mental health services? Yes _____ No _____

Give details on any previous services/treatment:

Provider	Year	Inpatient/Outpatient	Services/Treatment
1.			
2.			

NURSING HOME/CARE FACILITY RECORD

Have you had any previous admission(s) to a nursing or other care facility? Yes _____ No _____

Give details on any previous treatment:

Facility	Dates of Stay	Reason for Admission	Therapies Received
1.			
2.			

THERAPIES/HOME HEALTH SERVICES RECORD

Please describe any in-home services you have used in the past year, such as Occupational, Physical and/or Speech Therapy, Home Health Services, etc.

Provider	Dates of Service	Reason	Therapies or Services Received
1.			
2.			

MEDICAL HISTORY FOR APPLICANT #2 (IF APPLICABLE)

To determine eligibility of insurance benefits and for regulatory compliance, complete the following:

HOSPITALIZATION RECORD

Were you hospitalized in the last year? Yes _____ No _____

Complete the following for any hospitalizations within the last year **or** for the two most recent hospitalizations.

Hospital	Inpatient/ Outpatient	Dates of Hospitalization	Reason
1.			
2.			

Details on any other significant hospitalizations or surgeries:_____

_____

Hospital of choice for future hospitalizations:_____

MENTAL HEALTH RECORD

Have you ever received mental health services? Yes _____ No _____

Give details on any previous services/treatment:

Provider	Year	Inpatient/Outpatient	Services/Treatment
1.			
2.			

NURSING HOME/CARE FACILITY RECORD

Have you had any previous admission(s) to a nursing or other care facility? Yes _____ No _____

Give details on any previous treatment:

Facility	Dates of Stay	Reason for Admission	Therapies Received
1.			
2.			

THERAPIES/HOME HEALTH SERVICES RECORD

Please describe any in-home services you have used in the past year, such as Occupational, Physical and/or Speech Therapy, Home Health Services, etc.

Provider	Dates of Service	Reason	Therapies or Services Received
1.			
2.			

FINANCIAL STATEMENT (All questions must be answered to process the application.)

NAME: _____ **DATE:** _____

Have you (or your spouse) transferred any assets, including real estate, to someone other than your spouse for less than full market value within the past five (5) years? Yes _____ No _____

Have you (or your spouse) established a trust, or transferred any assets to a trust within the past five (5) years? Yes _____ No _____

If the answer is yes to either question, please use a separate sheet of paper to describe any transactions valued at more than $5,000.00. This information is being requested because such transactions can interfere with and delay eligibility for Medicaid , both now and in the future.

ASSETS	Applicant #1	Applicant #2
Checking Account	$	
Savings Account	$	
Certificates of Deposit	$	
Mutual Funds	$	
Stocks & Bonds	$	
IRA - 403(b) – 401(k)	$	
Trust Fund	$	
Annuities	$	
Value of Business	$	
Loans to Others	$	
Other	$	
TOTAL ASSETS	$	

MONTHLY INCOME	Applicant #1	Applicant #2
Social Security	$	
Pensions	$	
Annuities	$	
Interest/Dividends	$	
IRA/Bonds	$	
Rental Income	$	
Other:_____	$	
TOTAL MONTHLY	$	

LIABILITIES		
Monthly Rent	$	
Notes Payable	$	
Credit Card Debt	$	
Other :_____	$	
TOTAL LIABILITIES	$	

I own the above assets and they are available for payment of services I may receive at Fairmount Homes.

DESCRIPTION OF REAL ESTATE				
Property and Location	**Date Acquired (Approx.)**	**Purchase Price (Approx.)**	**Mortgage Remaining**	**Fair Market Value**
1.				
2.				

Fairmount Homes Retirement Community is a private, non-profit organization whose policy is to serve all residents without regard to race, color, national origin, ancestry, age, sex, religious creed, handicap or disability.

I understand that Fairmount will keep my information in strict confidence and will only use the information for necessary purposes, such as conducting criminal background checks as part of the standard admission process. To the best of my knowledge and belief, the information in this application is true and correct. Although the application is not otherwise binding, I understand and agree that any misrepresentation or significant omission or misstatement of fact, including financial information, may be considered grounds for refusal of residency or for dismissal (after admission) from Fairmount. In making this application for residency, I hereby declare that I have read and am familiar with the attached Fairmount "Pre-admission Information Sheet," and agree to accept the said regulations and do make this application without reserve.

I understand that Fairmount may request proof of financial status and periodic updated financial information. All applications are reviewed when admission is pending and updates will be required at that time. Applicants must meet the financial criteria in place at the time a residence is available for occupancy.

I certify the above information to be true and correct and authorize Fairmount Homes to research any information for verification.

Signature of applicant_____Date _____

Signature of person completing application, if other than applicant _____

EMERGENCY CONTACTS

Name	Relationship	Address	Telephone/Contact Info
		Street_____ _____ City_____ State_____Zip_____	Home _____ Work _____ Mobile _____ E-mail _____
Name	**Relationship**	**Address**	**Telephone/Contact Info**
		Street_____ _____ City_____ State_____Zip_____	Home _____ Work _____ Mobile _____ E-mail _____
Name	**Relationship**	**Address**	**Telephone/Contact Info**
		Street_____ _____ City_____ State_____Zip_____	Home _____ Work _____ Mobile _____ E-mail _____

OTHER INFORMATION

How did you hear about Fairmount? (Please check the **one** that most accurately answers the question.)

☐ Church
☐ Community Events
☐ Family (is/was) Here
☐ Friends Here
☐ Hospital/Physician Recommendation
☐ Social Media
☐ Publications
☐ Home Health Agency
☐ Internet Search
☐ Live Locally
☐ Other (Please specify) _____

What is your desired time frame for moving into Fairmount?

_____

_____

_____

333 Wheat Ridge Drive
Ephrata, PA 17522-8558
Phone: 717.354.1800 Fax: 717.354.6665
www.FairmountHomes.org

EQUAL HOUSING OPPORTUNITY

Revised 02/06/23

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333 Wheat Ridge Drive ◆ Ephrata, PA 17522-8558
Telephone: 717.354.1800 ◆ Fax: 717.354.6665
www.FairmountHomes.org

Dedicated to Faith, Family & Community

PRE-ADMISSION INFORMATION SHEET

(Please remove from application and keep with your records.)

Our Mission:

"Founded on Christ's love and Mennonite values, we strive to enrich the lives of those we serve."

Core Values:

Community ~ Compassion ~ Dignity ~ Integrity ~ Quality ~ Teamwork ~ Trust

GENERAL INFORMATION

Daily Rates: Daily residents' rates are determined by the type of care required at the time of admission and the doctors' orders. Rates may be adjusted at any time depending on the resident's physical and/or mental condition and the resulting required change in level of care.

Room Furnishings: All rooms are fully furnished in the Wheat Ridge Health Care and Personal Care areas. However, residents are encouraged to bring a favorite personal chair with them upon residency. Radios and disc players are permitted. Certain musical instruments may be brought with permission from Administration. Space is available for the storage of a chest or wardrobe, if desired. Residents may bring additional personal belongings as space permits with the emphasis placed on safety and neatness of living space. Television is permitted on the Farm Crest campus only, but not in the common areas. Cable connection is available at Farm Crest at the resident's own expense.

Clothing: Residents bring their own personal clothing with them when they move to Fairmount. In keeping with Fairmount's tradition, we would request that residents dress modestly.

Tobacco and Alcohol: The use of tobacco, alcohol or narcotics in any form is strictly forbidden, except for medical reasons.

Valuables: Fairmount Homes and its staff cannot be held responsible for any valuables (money, jewelry, watches, etc.) left in residents' rooms. Such items should be left with a family member or placed in the Administrative Office safe for security.

Persons making application to Fairmount must agree to the following terms and conditions:

1. I agree that upon residency at Fairmount, I will be subject to all rules and regulations with respect to Fairmount as formulated either by the Administration of Fairmount or by the Board of Directors. As a Fairmount resident, I agree that disregard for such rules and regulations shall be considered a basis for my dismissal.

2. I understand that the daily rate includes room, board, and care as stated on the current rate sheet. I further understand that at times, additional charges may incur due to special care needs above and beyond those considered normal. All rates are subject to change by decision of the Board of Directors of Fairmount.

3. In accordance with Fairmount's regulations, I agree to present any required statements and reports from my personal physician regarding my physical condition on the forms provided by Fairmount prior to admission.

4. Resident and the Responsible Person agree that they will exercise their authority with respect to Resident's assets and financial resources in such a manner as to insure that those assets (except incidental expenditures) are used solely for the benefit, care, and maintenance of Resident as long as this agreement remains in effect.

5. All financial information provided to Fairmount Homes and governmental authorities has been true and correct. Fairmount may request periodic updates on financial information and may require documentation of assets indicated on the financial statements.

12/20