INSTRUCTIONS

Thank you for choosing Cypress Glen Retirement Community as your new home. We are affiliated with the North Carolina Conference, Southeastern Jurisdiction, of the United Methodist Church. Applications are received and processed without regard to race, color, religion, sex, national origin or disability.

Application Checklist

- ❑ Check in the amount of $250.00 for an individual or $350.00 for a couple for the non-refundable application fee
- ❑ Copy of the last two years' Federal 1040 (front pages only)
- ❑ Substantiating evidence of financial information (from the Confidential Data Application form), i.e. bank statements, stock statements, etc.
- ❑ Copy of Medicare and health insurance cards (front and back)
- ❑ Copy of your Long Term Care Insurance policy, if applicable

Prior to move-in we will need the following:

- ❑ Copy of your Power of Attorney
- ❑ Copy of your Health Care Power of Attorney
- ❑ Copy of Living Will

Cypress Glen Retirement Community
Application for Residency

First Person: ____
Last First Middle

Telephone: ______________________________ Email :______________________________

Address: ____

____
City State Zip County

Present Marital Status: S____M____W____D____ Anniversary Date: ______________

Social Security #: ________-________-________ Date of Birth:_____/______/______

Power of Attorney:____
Name *Relationship*

____
Address

____
City *State* *Zip*

____
Phone Number(s)

Second Person: ____
Last First Middle

Telephone: ______________________________Email:______________________________

Address: ____

____
City State Zip County

Social Security #: ________-________-________ Date of Birth:_____/______/______

Power of Attorney:____
Name *Relationship*

____
Address

____
City *State* *Zip*

____
Phone Number(s)

P.2 – Cypress Glen Retirement Community - Application For Residency

Person/firm responsible for business affairs: ______________________________

Name *Relationship*

____

Address

____

Phone Number(s)

Children /Nearest Relatives/Emergency Contact Persons

1) ______________________________
Name/Relationship

____
Address

____
City *State* *Zip*

____
Phone Number(s)

2) ______________________________
Name/Relationship

____
Address

____
City *State* *Zip*

____
Phone Number(s)

3) ______________________________
Name/Relationship

____
Address

____
City *State* *Zip*

____
Phone Number(s)

4) ______________________________
Name/Relationship

____
Address

____
City *State* *Zip*

____
Phone Numbers(s)

I make this application for residency in the retirement community chosen above, sponsored by Cypress Glen Retirement Community of my own free will and accord. It is my purpose to make said retirement community my permanent home. I declare the foregoing to be true, full and complete.

______________ ______________________________

Date **Signature of First Person**

______________ ______________________________

Date **Signature of Second Person**

7/18
application for residency.doc

Cypress Glen Retirement Community
Confidential Data Application

	First Person	**Second Person**
Name:	______________________ *Last* *First* *Middle*	______________________ *Last* *First* *Middle*
Date of Birth:	______________________	______________________

ASSETS

It will be assumed that all assets listed will be available for your lifetime use.

DESCRIPTION	**FIRST PERSON**	**SECOND PERSON**	**Total/Combined**
Value of Residence	$____________	$____________	$____________
Other Real Estate Equity	$____________	$____________	$____________
Savings/CDs	$____________	$____________	$____________
Stocks/Bonds	$____________	$____________	$____________
Mutual Funds	$____________	$____________	$____________
IRA/401K	$____________	$____________	$____________
Roth IRA	$____________	$____________	$____________
Annuities	$____________	$____________	$____________
Trusts	$____________	$____________	$____________
Checking Accounts/Money Market	$____________	$____________	$____________
Life Insurance (Cash Value)	$____________	$____________	$____________

Total Assets $____________

LIABILITIES

Mortgage on Home/Real Estate $____________

Other Debts (Total) $____________

Total Liabilities $____________

NET WORTH

Total Assets *minus Total Liabilities* $____________

Long Term Care Insurance	**First Person**	**Second Person**
Benefit Period (Years)	____________	____________
Elimination Period (Days)	____________	____________
Home Care Daily Benefits	$____________	$____________
Assisted Living Daily Benefits	$____________	$____________
Nursing Care Daily Benefits	$____________	$____________
Inflation Adjusted (Yes/No)	____________	____________
Annual Premium	$____________	$____________
Premium Inflation (%)	____________	____________

MONTHLY INCOME

	First Person	Second Person	Total/Combined
Social Security	$______	$______	$______
Pension and Retirement	$______	$______	$______
Interest/Dividend Income	$______	$______	$______
Other Income	$______	$______	$______
Total Monthly Income	$______	$______	$______

Please identify the specific investment from which interest/dividend income is derived

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	$______	$______	$______
LTC insurance (if applicable)	$______	$______	$______
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 First Person**	**Second Person**

CYPRESS GLEN RETIREMENT COMMUNITY
Personal Health History

The Personal Health History of each Future Resident will be reviewed by the Cypress Glen clinical team to assess Future Resident needs and abilities as part of the medical requirement for admission. The information will need to be updated annually prior to the admission. Additionally, at such time the Future Resident signs a Residency Agreement, a Physician's Report will be submitted to his or her primary care physician for completion and request for medical history.

Name: ____________________________________**Date of Birth** ______________________ **Age** ____

Medicare #: ______________________________ Part(s) ______________________________

Health Insurance #2: ____

Co./Group No. ______________________________ Policy ID # _______________________________

Long Term Care Insurance _____Y _____N

Carrier __________________________________ Policy ID # ________________________________

Current Primary Physician: *A local primary physician is necessary prior to moving into Cypress Glen.*

(Name) ____

(Address) ____

____

(Phone) ____

Health Care Power of Attorney

(Name) ____

(Address) ____

____

(Phone) ____

Do you have a living will? Y/N

Please list your current medications including over the counter medications, aspirin, vitamins, and herbs *(continue back of page, if needed)*

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Medication: ______________________ Dosage: ______________ How Often: __________

Do you currently need assistance in managing medications? Yes____ No ____

Please list any medicine or food allergies and reactions

____

____

____

Please list any medical diagnoses

____

____

____

____

Medical Problems:

	Yes	No
Hepatitis (A, B, or C)	____	____
High Blood Pressure	____	____
Arthritis	____	____
Gastrointestinal	____	____
Gastroesophageal Reflux (GERD)	____	____
Stomach Ulcers	____	____
Irritable Bowel Syndrome (IBS)	____	____
Liver	____	____
Prostate	____	____
HIV/Aids	____	____
Tuberculosis	____	____
Migraines	____	____
Mental Illness	____	____
Heart Disease	____	____
Heart Defects	____	____
Heart Valve Problems	____	____
Prosthetic Implants	____	____
Lung Disease	____	____
Asthma	____	____
Emphysema/ COPD	____	____
Fibromyalgia	____	____
Osteoarthritis	____	____
Osteoporosis	____	____
Macular Degeneration	____	____
Glaucoma	____	____
Diabetes	____	____
Kidney Disease	____	____
Thyroid Disease	____	____
Anemia	____	____
Lupus	____	____
Lyme Disease	____	____
Crohn’s Disease	____	____

Medical Problems continued:

	Yes	No
Stroke	____	____
Epilepsy/ Seizures	____	____
Hay fever/ Allergies	____	____
Depression	____	____
Cancer	____	____
Sleep Apnea	____	____
Anxiety	____	____
Depression	____	____
Suicidal	____	____
Hospitalization for mental issues	____	____
Memory Loss/ Cognitive Disorders	____	____
Parkinson's	____	____
Dementia	____	____
Shingles	____	____
Bleeding/Clotting Disorder	____	____
Easy bleeding or bleeding after surgery	____	____
Require antibiotics for dental work	____	____
History of Alcoholism or Substance Misuse	____	____
Other ____________________________	____	____
Other ____________________________	____	____

Please further explain any medical problem where Yes was checked:

____

____

____

____

Surgeries or medical procedures in the past three years:

____

____

____

Do you have the:

	Yes	No
Ability to ambulate independently or with the assistance of auxiliary aids	____	____
Ability to use the toilet without assistance from others	____	____
Ability to self-administer medication responsibly without assistance	____	____
Ability to remember date, time, place, or person orientation	____	____
Ability to fully participate in planning and exercising good judgement in decisions made on matters of personal health and welfare, or ability to participate in planning and decision-making with minor dependence on others	____	____
Aware of and the ability to follow routine safety procedures without assistance	____	____
Ability to obtain items needed for daily living	____	____
Ability to manage own personal and financial matters in a responsible fashion	____	____
Ability to travel independently in a vehicle, or arrange for travel through mass transit or taxi services without assistance	____	____
Ability to bathe without assistance	____	____
Ability to groom hair, nails, body and clothing without assistance	____	____
Ability to dress appropriately without assistance	____	____
Ability to communicate independently or with the use of auxiliary aids	____	____
Ability to use and complete a telephone call without assistance	____	____

For each activity you require assistance with as noted on previous page, please explain how your need will be met.

____

____

____

Please answer the following:

	Yes	**No**
Do you smoke? *PLEASE NOTE: The residences and commons areas of Cypress Glen are smoke-free.*	____	____
Are you a current illegal abuser or addict of a controlled substance?	____	____
Have you been convicted of the illegal manufacture or distribution of a controlled substance?	____	____
In order to occupy your new residence, do you require special modifications to the space?	____	____

If you answered YES to any of the above questions, please explain

____

____

____

____

____

____

____

VACCINATION STATUS

Are you fully vaccinated against COVID? Yes No

Please provide a copy of your vaccination card, front and back

Have you received a Flu vaccine? Yes No

Date: ________________

Have you received a PNEUMOVAX vaccine? Yes No

Date: ________________

If you answered NO to any of the vaccination questions, 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.

____

Signature Date