



Application for Residency

Tel Hai Retirement Community
 1200 Tel Hai Circle – PO Box 190
 Honey Brook, PA 19344 Phone: 610/273-9333
 The Meadows Health Care Fax: 610/273-4041
 Lakeview Personal Care Fax: 610/273-4151



\$250.00
 Application Fee

PERSONAL INFORMATION:

Name	
Preferred Name	
Address	
City, State, Zip Code	
Home Phone	
Cell Phone	

Birth Date		Current Age		Social Security #	
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Marital Status	<input type="checkbox"/> Married	<input type="checkbox"/> Widowed	<input type="checkbox"/> Single	<input type="checkbox"/> Divorced
Spouse's Name				
Drug/Food Allergies				

INSURANCE INFORMATION:

LONG TERM CARE PROVIDER:

Medicare #		Daily Benefit	
Supplemental Insurance Co.		Yearly Increase	
Supplemental ID #		Policy Duration	
Managed Care Insurance Co.			
Managed Care ID #			

ADDITIONAL INFORMATION:

Hospital Preference	
Physician	
Religion/Place of Worship	
Funeral Director Name and Address	
City, State, Zip Code	

BILLING INFORMATION:

Name	
Relationship	<input type="checkbox"/> POA <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Grandchild <input type="checkbox"/> Other
Address	
City, State, Zip Code	
Home Phone	
Cell Phone	
Work Phone	
Email	

AUTHORIZED EMERGENCY CONTACTS:

Name	
Relationship	<input type="checkbox"/> POA <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Grandchild <input type="checkbox"/> Other
Address	
City, State, Zip Code	
Home Phone	
Cell Phone	
Work Phone	
Email	

Name	
Relationship	<input type="checkbox"/> POA <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Grandchild <input type="checkbox"/> Other
Address	
City, State, Zip Code	
Home Phone	
Cell Phone	
Work Phone	
Email	

Name	
Relationship	<input type="checkbox"/> POA <input type="checkbox"/> Spouse <input type="checkbox"/> Daughter <input type="checkbox"/> Son <input type="checkbox"/> Grandchild <input type="checkbox"/> Other
Address	
City, State, Zip Code	
Home Phone	
Cell Phone	
Work Phone	
Email	

FINANCIAL INFORMATION:

List Regular Monthly Income

Social Security Amount	\$	per month
Pension or Annuities	\$	per month
Dividends	\$	per month
Rental Income	\$	per month
Mortgage Income	\$	per month
Trust Income	\$	per month
Other Income	\$	per month
Total Income	\$	per month

Capital Assets & Name of Financial Institution Holding Funds

Cash	\$	
Savings	\$	
Checking	\$	
Certificates of Deposit	\$	
Stocks & Bonds	\$	
Home	\$	
Other Real Estate	\$	
Life Insurance (<i>cash value</i>)	\$	
Other Assets	\$	
Total Assets	\$	

Liabilities:

Estimated Monthly Medical Expenses:

Mortgages/Line of Credit/	\$	Medications	\$
Reverse Mortgage	\$		
Notes Payable	\$	Medical Supplies	\$
Notes Endorsed	\$	Medicare	\$
Personal Debts	\$	Co-Insurance	\$
Credit Card Balance(s)	\$	Other	\$
Total Liabilities	\$	Total Expenses	\$

Within the past 5 years, have you or your spouse given away, sold or transferred any assets such as: a home, land, personal property, life insurance policies, annuities, bank accounts, certificates of deposit, stocks, IRA, bonds or right to income? Yes No

Asset		Asset	
Date of Disposition		Date of Disposition	
Amount Disposed	\$	Amount Dispose	\$

I do hereby certify that the information listed is true and complete to the best of my knowledge.

Date: _____ Signature: _____

Please include copy of Power Attorney, Medicare Card (both sides), insurance cards (both sides), Living Will or Advanced Directives, Photo ID, Social Security card and supporting documents for the assets shown on this application.