☐ INDEPENDENT LIVING
☐ PERSONAL CARE
☐ SKILLED NURSING

ELM TERRACE GARDENS
LANSDALE, PENNSYLVANIA

APPLICATION FOR RESIDENCE

660 NORTH BROAD STREET · LANSDALE, PENNSYLVANIA 19446-2361 · **(215) 361-5600**

Name: Miss / Mrs. / Mr. ____
Last First Middle

Address: ____
Street City State Zip Code

Phone Number: ____________________ Birth date: ____________________ (MM, DD, YYYY)

Cell: ____________________ Email: ____________________

Social Security Number: ____________________ Medicare Number: ____________________

Health Insurance Company (copies of cards required): ____________________

ID Number: ____________________ Plan: ____________________ Group: ____________________

Marital Status (Circle One): Married Single Widowed Divorced

Name of Spouse (Living or Deceased): ____________________

Power of Attorney (Document required) Name: ____________________

Relation: ____________________ Is POA Durable? YES NO

Phone Number: ____________________ Cell: ____________________

Address: ____
Street City State Zip Code

Email: ____________________

Is POA currently responsible for payment of bills? Yes No

Emergency Contact: ____________________ Relation: ____________________

Phone Number: ____________________ Cell: ____________________

Address: ____
Street City State Zip Code

Email: ____________________

Licensed to drive a car? YES NO Would you bring a car? YES NO

Insurance Carrier : ____________________ Policy No. ____________________

Desired date of residence at Elm Terrace Gardens: ____________________

Desired Accommodation: Studio 1 Bedroom 2 Bedroom Semi-Private Suite Private Suite

FINANCIAL REPRESENTATION AS OF ________________________
Date

	JOINT	APPLICANT 1	APPLICANT 2
CASH FLOW-MONTHLY **Income:**			
Social Security			
Pension What portion will remain for your spouse in the event of your death?			
IRA/401(k)			
Trust Income			
Other Description:			
TOTAL MONTHLY INCOME			
Expenses:			
Health Insurance Premiums			
Life Insurance Premiums			
Prescriptions/Medicare Part D			
Long-Term Care Insurance Premiums			
Food			
Auto			
Personal			
Other Description:			
TOTAL MONTHLY EXPENSES			
ASSETS			
Checking Account Balance			
Savings Account Balance			
Stock Investments			
Real Estate			
Life Ins. Death Benefit			
Other Assets Please describe			
Other Assets Please describe			
TOTAL ASSETS			
LIABILITIES			
Mortgage Balance			
Other Loan Balances			
Credit Card Balance			
Other Debt Description:			
TOTAL LIABILITIES			

COST COMPARISON

Fill out the chart below to find out how joining the Elm Terrace Gardens community can help save you money. A monthly service fee can help make your cost of living easier to handle and in most cases, more affordable as well.

Monthly Comparison

Item	Monthly Cost Now	Monthly Cost at ETG
Rent/Mortgage Payments	$	Included
Property Taxes	$	Included
Fire/Flood Insurance	$	Included
Heat	$	Included
Electric	$	Included
Sewer & Water	$	Included
Trash/Recycle Service	$	Included
Basic Cable TV	$	Included
Appliance Repair/Replacement	$	Included
Home Repair/Upkeep Costs	$	Included
Mowing/Snow Removal/Garden upkeep	$	Included
Long Term Care Insurance	$	Included
Transportation: Auto maintenance, gas, insurance.	$	Some transportation included
Groceries & Dining out	$	2 meals included-options available
24-hour Emergency Response System	$	Included
Entertainment	$	Included
Social & Educational Activities	$	Included
TOTALS	Total monthly cost for your current home: $____________________	Monthly fees as of 7/1/11: (additional options available) 1 person / 2 person Studio: $1,810 / N/A One Bedroom: $2,110 / $3,590 Two Bedroom: $2,330 / $3,780
Privete Pay Vs. Lifecare	**Private Pay Contract**	**Lifecare Contract**
Personal Care	$5,100/mo. minimum	Same monthly fee as apartment-see above
Skilled Nursing	$9,000/mo. minimum	Same monthly fee as apartment-see above

CONFIDENTIAL HEALTH QUESTIONNAIRE

Primary Physician Name: ______________________________________Phone Number: ____________________

Address: ____
Street City State Zip Code

Date of last physical exam: ____________Condition treated for: ______________________________________

Specialist Physician Name: ____________________________________Phone Number: ____________________

Address: ____
Street City State Zip Code

Sex__________ Height _________ Weight __________

Answer the following questions, circling yes or no, or filling in the blank where appropriate.
All answers are confidential.

1. Has there been any change in your general health within the past year?___________________YES NO

2. Are you under the care of a physician?____YES NO
   If so, what is the condition being treated? _______________________________________

3. Have you been hospitalized or had a serious illness or operation within the past five (5) years?____YES NO
   If so, what was the problem? ____

4. Do you have or have you had any of the following diseases or problems?
   a. Rheumatic fever or rheumatic heart disease __________________________________YES NO
   b. Congenital heart lesions ____YES NO
   c. Cardiovascular disease (heart trouble, heart attack, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis________________________YES NO
      1) Do you have pain in chest upon exertion? ___________________________YES NO
      2) Are you ever short of breath after mild exercise?______________________YES NO
      3) Do your ankles swell? ____YES NO
      4) Do you get short of breath when you lie down, or do you require extra pillows when you sleep?________________________________YES NO
   d. Sinus trouble ____YES NO
   e. Asthma or hay fever ____YES NO
   f. Hives or skin rash ____YES NO
   g. Fainting spells or dizziness ____YES NO
   h. Diabetes ____YES NO
      1) Do you have to urinate more than six (6) times a day?_________________YES NO
      2) Are you thirsty much of the time?___________________________________YES NO
      3) Does your mouth frequently become dry______________________________YES NO
   i. Hepatitis, Jaundice, or Liver disease ____YES NO
   j. Arthritis ____YES NO
   k. Inflammatory Rheumatism (painful, swollen joints_____________________________YES NO
   l. Stomach Ulcers____YES NO
   m. Kidney Trouble ____YES NO

n. Tuberculosis ______ YES NO
o. Do you have a persistent cough or cough up blood? ______ YES NO
p. Low Blood Pressure ______ YES NO
q. Emphysema or Chronic Lung Condition ______ YES NO
r. Anemia ______ YES NO
s. Have you had abnormal bleeding associated with surgery or trauma? ______ YES NO
t. Do you bruise easily? ______ YES NO
u. Have you ever required a blood transfusion? ______ YES NO
If yes, please explain the circumstances ______
v. Cataracts ______ YES NO
w. Have you had surgery for cataracts? ______ YES NO
x. Have you been treated for a tumor or growth? ______ YES NO
If yes, please explain. ______
y. Memory loss ______ YES NO
z. Difficulty Speaking ______ YES NO
aa. Paralysis ______ YES NO
If yes, please explain. ______
bb. Do you have any other disease, condition , or problem not listed above? ______ YES NO
If yes, please list. ______

5. Are you taking any of the following medications:
a. Antibiotic or Sulfa Drugs ______ YES NO
b. Anticoagulants (Blood thinners) ______ YES NO
c. High Blood Pressure Medicine ______ YES NO
d. Cortisone (Steroids) ______ YES NO
e. Tranquilizers ______ YES NO
f. Antihistamines ______ YES NO
g. Aspirin ______ YES NO
h. Insulin ______ YES NO
i. Digitalis or drugs for heart trouble ______ YES NO
j. Nitroglycerin ______ YES NO
k. Other (Please list): ______
______

6. Are you allergic or have you reacted adversely to:
a. Local anesthetics ______ YES NO
b. Penicillin or other antibiotics ______ YES NO
c. Sulfa Drugs ______ YES NO
d. Barbiturates, Sedatives, or Sleeping Pills ______ YES NO
e. Aspirin ______ YES NO
f. Iodine ______ YES NO
g. Codeine or other Narcotics ______ YES NO
h. Other (Please list) ______

7. Do you use any of the following:
a. Glasses or Contacts ______ YES NO
b. Dentures or Partials ______ YES NO
c. Wheelchair ______ YES NO
d. Walker or Cane ______ YES NO

FAMILY CONTACT INFORMATION

Relationship:________________________________ Gender:_______

First Name: ________________________________ Middle Name:________________Last Name:_______________

Address: __________________________________City:___________________ State:________ZIP:________________

Home Phone:_______________________________Work Phone:__________________Cell:______________________

Email:____

Relationship:________________________________ Gender:_______

First Name: ________________________________ Middle Name:________________Last Name:_______________

Address: __________________________________City:___________________ State:________ZIP:________________

Home Phone:_______________________________Work Phone:__________________Cell:______________________

Email:____

Relationship:________________________________ Gender:_______

First Name: ________________________________ Middle Name:________________Last Name:_______________

Address: _________________________________ City:__________________ State:________ZIP:________________

Home Phone:_______________________________Work Phone:__________________Cell:______________________

Email:____

Relationship:________________________________ Gender:_______

First Name: ________________________________ Middle Name:________________Last Name:_______________

Address:__________________________________ City:____________________ State:______ ZIP:__________

Home Phone:_______________________________ Work Phone:_________________ Cell:_________________

Email:____

Church Affiliation: __________________________ Pastor's Name____________________________________

Phone Number: _______________________________________ Cell : __________________________________

Funeral Director: ____Phone Number: __________________

Address: ____

Street City State Zip Code

Legal Information

Power of Attorney for Healthcare: (Please supply a copy):

Resident Has POA for Healthcare: YES NO

Location of Document:___________________________________

Name of POA for Healthcare:____ Gender:____________________

Address: ____________________________________City:___________________ State:________ZIP:________________

Home Phone:_________________________________Work Phone:___________________Cell:_______________________

Email:____

Living Will (Please supply a copy):

Resident Has Living Will: YES NO Location of Living Will Document:_________________________

Holder of Living Will:____ Gender:___________________

Address: ____________________________________City:___________________ State:________ZIP:________________

Home Phone:_________________________________Work Phone:___________________Cell:_______________________

Email:____

Legal Will:

Resident Has Legal Will: YES NO Location of Legal Will Document:_________________________

Holder of Legal Will:____ Gender:____________________

Address: ____________________________________City:___________________ State:________ZIP:________________

Home Phone:_________________________________Work Phone:___________________Cell:_______________________

Email:____

Executor of Estate:

Name of Executor:____ Gender:____________________

Address: ____________________________________City:___________________ State:________ZIP:________________

Home Phone:_________________________________Work Phone:___________________Cell:_______________________

Email:____

ACKNOWLEDGEMENT

The assets listed in this application are controlled by me (us) in my (our) individual or joint names and held for my (our) benefit. We are prepared to pay for all levels of care at Elm Terrace Gardens. I (We) understand and acknowledge that Elm Terrace Gardens relies on the information and disclosures made in this application for the purpose of inducing Elm Terrace Gardens to consider me (us) for admission. I (We) certify that the information and disclosures provided in this application are true, correct and complete to the best of my (our) knowledge.

APPLICANT #1 Signature ____ Date ________________________

APPLICANT #2 Signature ____ Date ________________________

Name of person completing this form other than Applicant #1 or #2 Relationship to Applicant (s) ______________________

Signature ____ Date ________________________

OUR MISSION

Elm Terrace Gardens, a nonprofit corporation, serves older adults by providing independent living, personal care and skilled nursing services in a safe, caring, attractive, stimulating and spiritually nourishing environment. Accordingly, we seek the highest levels of resident well-being in the context of state-of-the-art long term care.