

**Application for Residency**  
**Countryside Christian Community**  
**200 Bellann Court, Annville, PA 17003-9012**  
**717-867-4636**

Note: This application must be completed in its entirety to be considered for residency or a waiting list. No information included herein will be shared with other individuals or parties not necessary for the processing of your application to the community.

**Today's Date:** \_\_\_\_\_

**Application is for:** (Check only one)

Nursing care \_\_\_\_\_  
 Personal Care \_\_\_\_\_  
 Respite Care \_\_\_\_\_  
 Cottage \_\_\_\_\_

**For office use only:**

Application received _____	Admission policy & disclosure provided:	
Approved for admission _____	Initials: _____	Date: _____
Date of arrival _____	_____	_____
Admitted from _____	_____	_____
Contact start date _____	_____	_____

**Applicant's Name:**

Last \_\_\_\_\_ First \_\_\_\_\_ Middle \_\_\_\_\_ Maiden \_\_\_\_\_

Marital Status: (Circle one)    Single            Married            Widow/Widower            Divorced            Co-habitant

If admission is desired for you and a co-applicant, indicate name of co-applicant: \_\_\_\_\_

If you are seeking admission to the cottages, please specify your date of birth: \_\_\_\_\_.

**Current Address:**

Street \_\_\_\_\_ Town \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # (    ) \_\_\_\_\_ Cell Phone # (    ) \_\_\_\_\_ Work Phone # (    ) \_\_\_\_\_

E-mail Address \_\_\_\_\_ Can we use your e-mail for communication?            Yes    No

Social Security Number \_\_\_\_\_

Medicare Number \_\_\_\_\_ (If applicable, Medicaid #): \_\_\_\_\_

Medicare Insurance plan \_\_\_\_\_ ID# \_\_\_\_\_

**Insurance Information**

Secondary Insurance to Medicare (Co-insurance) \_\_\_\_\_

Group Number \_\_\_\_\_ ID# \_\_\_\_\_

Type of plan if known: (HMO, PPO, PPS, std. plan, etc.): \_\_\_\_\_

Do you have long-term care insurance? Yes \_\_\_\_\_ No \_\_\_\_\_ Company \_\_\_\_\_

Benefit Period \_\_\_\_\_ Daily Benefit \_\_\_\_\_

(Please attach a copy of the long-term care insurance policy schedule)

Coverage included: (Skilled nursing, personal care, etc.): \_\_\_\_\_

Military Veteran:    Yes \_\_\_\_\_            No \_\_\_\_\_

Is or was your spouse a veteran    Yes \_\_\_\_\_            No \_\_\_\_\_

Have you ever been convicted of a felony?    Yes \_\_\_\_\_            No \_\_\_\_\_

How did you first learn about Countryside Christian Community? \_\_\_\_\_

**The type of living accommodation you prefer is: (Circle only one)**

Healthcare or Personal Care: semi-private room            private room

Cottage:    one-bedroom cottage            two-bedroom cottage            two-bedroom cottage w/garage

If considering a cottage, do you expect to bring a pet to live with you?    Yes    No    If yes, what type \_\_\_\_\_

**Names and addresses of children, powers of attorney, brothers/sisters or other close relationships:**

(List first the person of primary contact (other than applicants) and check the appropriate boxes.

**POA?**

**Receive Billings?**

<b>Name</b> _____	<b>Relationship</b> _____	<b>Phone</b> _____	Cell Phone _____	<input type="checkbox"/>	Yes	No
Address _____		Town _____	State _____	Zip _____		
<b>Name</b> _____	<b>Relationship</b> _____	<b>Phone</b> _____	Cell Phone _____	<input type="checkbox"/>	Yes	No
Address _____		Town _____	State _____	Zip _____		
<b>Name</b> _____	<b>Relationship</b> _____	<b>Phone</b> _____	Cell Phone _____	<input type="checkbox"/>	Yes	No
Address _____		Town _____	State _____	Zip _____		

Name and address of person holding power of attorney for applicant: (If you do not have a power of attorney, check here) \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

E-mail Address \_\_\_\_\_ Can we use your e-mail for communication? Yes No

Does the Power of Attorney document provide that it continue to be effective if the applicant is incompetent? Yes No

Name of primary physician \_\_\_\_\_ Phone \_\_\_\_\_

Date of your last medical examination \_\_\_\_\_

Do you use tobacco, alcohol or controlled substance in any form? (Circle one) No Yes

If yes, state what substances are used \_\_\_\_\_

**The following health information will be used solely to determine the appropriate level of care suited to the applicant's needs.**

**APPLICANTS SEEKING ADMISSION TO THE COTTAGES:**

**Present condition of health** (Describe any illness or physical limitations that may affect your ability to meet the conditions of occupancy, which conditions of occupancy are attached hereto): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Describe any serious illness(s) you have had in the past which may affect your ability to meet the conditions of occupancy:**

Currently taking medication for this illness?

_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No

**List any hospital admissions and/or surgical procedures within the last year that may affect your ability to meet the conditions of occupancy:**

Hospital	Explain
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

**APPLICANTS SEEKING ADMISSION TO THE NURSING OR PERSONAL CARE FACILITY:**

**Present condition of health** (Describe any illness or physical limitations): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Describe any serious illness(s) you have had in the past:**

**Currently taking medication for this illness?**

_____	Yes	No
_____	Yes	No
_____	Yes	No
_____	Yes	No

**List any hospital admissions and/or surgical procedures within the last year:**

Hospital	Explain
_____	_____
_____	_____
_____	_____
_____	_____

**ALL APPLICANTS:**

**List any other institution(s) with which you have resided:**

\_\_\_\_\_ Length of stay: \_\_\_\_\_ Date(s): \_\_\_\_\_  
\_\_\_\_\_ Length of stay: \_\_\_\_\_ Date(s): \_\_\_\_\_

When would you ideally like to move to the Community? Month \_\_\_\_\_ Year \_\_\_\_\_

If this application is not for consideration of immediate residency you will be placed on the Waiting List. A \$30 non-refundable application fee is required

**Complete Sections A & B only if you are applying for the Skilled Nursing Unit**

A. Do you currently require any form of psychiatric treatment? If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

B. Do you currently require any specialized care due to a physical and/or cognitive impairment? If yes, please explain:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

# Admission Application Agreement

This Application Agreement is made between Countryside Christian Community and the Applicant stated within or the Applicant's legal representative and or representative individual having lawful access to Applicant's income and financial resources available to pay for the services provided to Applicant.

WHEREAS, the information and disclosures provided in this Application Agreement by the Applicant and/or Responsible Person are made for the purpose of inducing Countryside Christian Community to consider the Applicant for admission into the Community.

WHEREAS, Countryside Christian Community relies on this Application Agreement, among other factors, for the determining whether to admit the Applicant into the Community in accordance with the terms and conditions of the Admission Agreement.

WHEREAS, Countryside Christian Community shall keep all information and disclosures in this Application Agreement confidential and include the Application Agreement as part of the Admission Agreement.

WHEREAS, the Applicant and/or Responsible Person authorizes Countryside Christian Community to obtain financial information from the financial institutions or other institutions identified on the Application Agreement and agrees to execute any releases requested by Countryside Christian Community for the purpose of verifying any and add representations regarding Applicant's financial resources and assets that Applicant and/or Responsible Person has made in the Application Agreement.

THEREFORE, the Applicant and/or Responsible Person provides the above information to Countryside Christian Community for consideration in the Admission review process. The Applicant and/or Responsible Person acknowledge and attest that the information and disclosures included herein are true and correct to the best of his/her/their knowledge and belief:

Applicant and/or Responsible Person Acknowledge that he/she/they understand that the information and disclosures provided in the Application Agreement do not obligate Countryside Christian Community to accept the Applicant for admission and are used only in the admission decision-making process.

By signing below, the Applicant and/or Responsible Person certifies that the information and disclosures provided in this Application Agreement are true correct and complete to the best of his/her/their knowledge and belief. Any false information, misrepresentation of information or lack of disclosure in this Application Agreement may result in the rejection of the Applicant's application and/or the termination of the Admission Agreement after admission at any time Facility learns of the false information, misrepresentation or lack of disclosure.

IN WITNESS WHEREOF, the parties, intending to be legally bound hereby, have signed this Application

Agreement on this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

Applicant's or  
Responsible  
Party's signature: \_\_\_\_\_ Witness: \_\_\_\_\_

(Consideration of this application for admission or a waiting list will not be made without signature!)

Countryside Christian Community Representative: \_\_\_\_\_ Witness: \_\_\_\_\_

## Financial Supplement

Assets & income owned by the applicant(s). Indicate if assets are intermingled with someone else other than spouse. Applicants failing to include all assets and income may face the rejection of their application or discharge from the community

Applicant Name \_\_\_\_\_

### Income

<u>Sources of Income</u>	<u>Frequency of Income</u> <small>(quarterly, monthly)</small>	<u>Gross Amount</u>	<u>Deductions</u>	<u>Cash or Check Amount</u>
Social Security	_____	_____	_____	_____
Pension	_____	_____	_____	_____
Interest	_____	_____	_____	_____
Dividends	_____	_____	_____	_____
Mutual Funds	_____	_____	_____	_____
Insurance/Annuities	_____	_____	_____	_____
*Trust	_____	_____	_____	_____
Employment Income	_____	_____	_____	_____
Veterans Benefit	_____	_____	_____	_____
Other Income (Describe)	_____	_____	_____	_____

\*Deductions may include Medicare Payments, Health Insurance Premiums, Income Tax Withheld, etc. Please indicate details of any survivor benefit available.

**Do you have pre-planned/paid funeral arrangements?**                      **Yes**                      **No**

**If yes, complete the following:**

Funeral Home \_\_\_\_\_ Phone Number \_\_\_\_\_

Bank/ Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Can money be withdrawn before death of individual?                      Yes                      No

Can interest be withdrawn?                      Yes                      No

**Within the past (5) five years have you (or your spouse) closed , given away, sold or transferred any assets such as, but not limited to: a home, land, personal property, life insurance policies, annuities, bank accounts, certificates of deposit, stocks, IRA, bonds, trust funds or a right to income?**

\_\_\_\_ No

\_\_\_\_ Yes - Explain circumstances, such as date, amount and recipient. Include documentation/verification.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**I own the assets listed below and they are available for payment of service I may receive at Countryside Christian Community.**

**Assets**

**Bank Accounts (Checking, Savings, Money Market, IRA, Certificate(s) of Deposit, etc.)**

(List all accounts that include applicant's and/or spouse's name & money)

<u>Bank Name</u>	<u>Account Type</u>	<u>Account Number</u>	<u>Current Balance</u>	<u>Name(s) on Account</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Stocks, Bonds (include U.S. Savings Bonds), Trusts, Mutual Funds, etc.**

<u>Name on Investment</u>	<u>Type Account</u>	<u>Account Number</u>	<u>Current Account Value</u>	<u>Name(s) on Account</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

**Life Insurance**

<u>Company Name</u>	<u>Policy Number</u>	<u>Face Value</u>	<u>Current Cash Value</u>	<u>Who owns the Policy?</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____



**3. Do you have any pending legal action from which you may receive money or medical benefits, including inheritance? If yes, describe.**

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

I certify the above information to be true and correct and authorize Countryside Christian Community to research any above information for verification. I understand that Countryside Christian Community may request proof of financial status.

By my signature below, I hereby authorize the nursing home to contact the County Assistance Office for information regarding my Medical Assistance application and eligibility, and I hereby release and authorize the County Assistance Office to release any information to the nursing home. I also authorize the nursing home to contact any and all of the above-identified financial institutions to obtain information regarding my assets and income, and I hereby authorize the financial institutions to release any information to the nursing home.

\_\_\_\_\_  
Resident/Responsible Party, POA

\_\_\_\_\_  
Date