



CYPRESS GLEN

— SENIOR LIVING —

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) _____ 3) _____
Name/Relationship Name/Relationship

Address Address

City State Zip City State Zip

Phone Number(s) Phone Number(s)

2) _____ 4) _____
Name/Relationship Name/Relationship

Address Address

City State Zip City State Zip

Phone Number(s) 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



**Cypress Glen Retirement Community
Confidential Data Application**

First Person

Second Person

Name: _____
Last First Middle

Name: _____
Last First Middle

Date of Birth: _____

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 (%)	_____	_____

P. 2 Cypress Glen Retirement Community - Confidential Financial Statement

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: _____
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?	_____	_____
<i>PLEASE NOTE: The residences and commons areas of Cypress Glen are smoke-free.</i>		
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