"In keeping with our United Methodist tradition, we seek to enhance the quality of life and holistic growth of older persons."

Application for Residency

Updated December 2020

PERSONAL INFORMATION *(Use separate form for spouse)*

Applicant's Full Name:_____

Street Address:_____

Zip Code:_____ Home Phone:_____Cell Phone:_____

Email Address_____ Social Security No.:_____

Date of Birth:_____ Birthplace (City & State):_____

County of Residence: _____ How Long: _____

Occupation (previous if applicable: _____ Retired:_____

Military Service ○ Yes ○ No Branch: _____

Marital Status (check one): ○ Single ○ Married ○ Divorced ○ Widowed

Spouse's Name: _____

Date of Birth: _____ Social Security No.: _____

Anniversary Date: _____ Highest level education completed: _____

SOCIAL AFFLILIATIONS – MEMBERSHIP

Service Clubs: _____

Social Clubs: _____

Veterans Clubs: _____

SPIRITUAL LIFE

Place of Worship: _____Denomination: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Church Phone: _____

Name of Clergy: _____

EMERGENCY INFORMATION

Next of kin: Children or other family members, friends, trust officers, attorneys in sequence to be notified in case of emergency.

1st CONTACT Person to be contacted regarding information relating to your case

Name: _____ Relationship: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Email Address: _____

Home Phone: _____ Bus. Phone: _____ Cell Phone: _____

2nd CONTACT

Name: _____ Relationship: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Email Address: _____

Home Phone: _____ Bus. Phone: _____ Cell Phone: _____

3rd CONTACT

Name: _____ Relationship: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Email Address: _____

Home Phone: _____ Bus. Phone: _____ Cell Phone: _____

FINANCIAL REPRESENTATIVE *(Required for Assisted Living & Nursing applicants)*

Person/Business to receive monthly bills **IF other than self**

Name: _____ Relationship: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Email Address: _____

Home Phone: _____ Bus. Phone: _____

FINANCIAL DISCLOSURE

Include copies of all supporting documentation.

ASSETS	Checking, savings, CDs, money markets, etc.	$_____
	Stocks, bonds, mutual funds, etc.	$_____
	Real Estate	$_____
	Additional Real Estate	$_____
	Other (describe):_____	$_____
	Total	**$**_____

MONTHLY EXPENSES	Auto loans	$_____
	Home mortgages	$_____
	Other loans	$_____
	Credit Cards	$_____
	Insurance (health, life, auto, long-term care)	$_____
	Medications	$_____
	Contributions	$_____
	Other (describe): _____	$_____
	Total	**$**_____

MONTHLY INCOME	Social Security	$_____
	Pensions (Survivorship _____%)	$_____
	Income from annuities, investments (Do not include if listed in assets)	$_____
	Other (describe): _____	$_____
	Total	**$**_____

TRANSFERS

Have you created any trusts? ○ Yes ○ No Date of Trust: _____

If yes, Type: _____

Have you transferred assets (i.e. gifts, real estate, bank accounts, etc.) to anyone within the last thirty-six (36) months (3 years)? ○ Yes ○ No

To: _____ Asset: _____

Please indicate the arrangements you are currently using for social security and pension income checks: ○ Mailed to my address ○ Direct Deposit (If so, please indicate name of bank)

The undersigned person(s) represents that the information contained on this application form and any attached documents are true to the best of his/her/their knowledge and belief. The undersigned person(s) understands that Otterbein Homes will rely upon the information in this application to determine eligibility for residency. The undersigned person(s) understands that the assets and income listed on the application may not be impaired by transfer to someone else without consent of the retirement community. The undersigned person(s) extends immunity to and hereby releases Otterbein Homes and any persons or entities from any and all liability arising out of the release of information, including otherwise privileged or confidential information.

Photocopies of this release will be binding as the original

The undersigned person(s) warrant that they can legally give the consent and authorizations made above.

You will be asked to update the information on your application prior to admission.

Name (print) _____ Spouse (print) _____

Applicant Signature _____ Date _____

Spouse Signature _____ Date _____

Accommodation Requested: ○ Independent ○ Assisted Living ○ Nursing

Please mail your completed application for residency to the Community/Neighborhood you wish to join:

Otterbein Cridersville
100 Red Oak Drive
Cridersville, Ohio 45806

Otterbein Lebanon
585 N. State Route 741
Lebanon, OH 45036

Otterbein Marblehead
9400 North Shore Blvd
Lakeside-Marblehead, OH 43440

Otterbein Gahanna Neighborhood
402 Liberty Way
Gahanna, OH 43230

Otterbein Loveland Neighborhood
750 Loveland-Miamiville Road
Loveland, OH 45140

Otterbein Maineville Neighborhood
201 Marge Schott Way
Maineville, OH 45039

Otterbein Pemberville
20311 Pemberville Road
Pemberville, Oh 43450

Otterbein St. Marys
11230 State Route 364
St. Marys, OH 45885

Otterbein Middletown Neighborhood
105 Atrium Drive
Franklin, OH 45005

Otterbein Monclova Neighborhood
5069 Otterbein Way
Monclova, OH 43542

Otterbein New Albany Neighborhood
6690 Liberation Way
New Albany, OH 43054

Otterbein Perrysburg Neighborhood
3529 Rivers Edge Dr
Perrysburg, OH 43551

Otterbein Springboro Neighborhood
9320 Avalon Circle
Centerville, OH 45458

Otterbein Union Township
4150 Bach Buxton Road
Batavia, OH 45103

Otterbein Senior Lifestyle Choices' does not discriminate on the basis of race, color, religion, sex, age, handicap, familial status, or nation origin. You must be 55 years old and older to reside in Independent Living or Assisted Living areas.

HEALTH INSURANCE *(Use separate form for spouse)*

List health and prescription drug insurance *(provide copies of the front and back of all health and insurance cards):*

Long term care insurance: ○ Yes ○ No

Company _____ Policy Number _____

Daily Benefit (nursing) $ ____ Daily Benefit (assisted living) $____ Monthly Premium $_____

○ Yes ○ No Plan A Policy Number: _____

Medical Insurance: ○ Yes ○ No

Company_____ Policy Number _____

Prescription Drug Insurance ○ Yes ○ No

Company _____ Policy Number _____

HMO's or others: _____ Policy Number _____

Medicaid Number: _____ Policy Number _____

PHYSICIANS *(Use separate form for spouse)*

Family Physician: _____ Date of last visit: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____

Dentist: _____ Date of last visit: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____

Eye Doctor: _____ Date of last visit: _____

Street Address: _____ City: _____ State: _____

Zip Code: _____ Phone: _____

ADVANCED PLANNING *(Use separate form for spouse)*

Durable Power of Attorney for Health Care: _____Living Will (copies needed): _____

Describe funeral plans. Funeral Home must be identified even if no contract exits.

Pre-paid funeral plans: ○ Yes ○ No Policy Number: _____

Place of internment: _____ City:_____ State: _____

Funeral Home: _____ City: _____ State: _____

Zip Code: _____ Phone: _____

AUTHORIZATION *(Use separate form for spouse)*

Otterbein Lifestyle Communities are committed to providing our residents with privacy, but from time to time you may want to share personal information - your background, hometown, marital status, spouse name, children's names, occupations, hobbies, and/or information such as your hospitalizations and/or temporary stays in nursing or assisted living; with your neighbors.

Release of Personal Information for Community Directories
I authorize use of personal information in facility directories, morning announcements, closed circuit TV, bulletin boards, and other means of communications with the community.

Signature of Applicant: _____ Date: _____

Release of Personal Information Hospital Stays & Temporary Stays
I authorize the use of my personal information in materials that are posted and distributed within the Otterbein Lifestyle Communities. This authorization is valid from the time of signature until I leave the community. I reserve the right to resign this authorization if I so choose at a later date.

Signature of Applicant: _____ Date: _____

Release of Medical Records
I authorize the release of my medical records to Otterbein Lifestyle Communities form my physicians, hospital, and health care agencies for the purpose of Otterbein Lifestyle Community's review and processing of my residency application.

Name: _____ Date: _____

I HEREBY CERTIFY that I make this application of my own free will. It is my purpose to make Otterbein Lifestyle Communities my home. In completing the Residency Application, I declare that all statements made herein are true, full, and complete to the best of my knowledge.

Signature of Applicant: _____ Date: _____

I, the undersigned Representative, interested in the applicant's residency, declare that all statements made herein are true, full, and complete to the best of my knowledge.

Signature of Representative: _____ Date:_____