

# The Hearth

..... at Drexel .....

## APPLICATION FOR RESIDENCY

Please return completed application to the Sales Office:

*Kylie Hood, CDP*

*Director of Sales & Marketing*

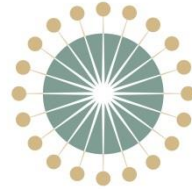
Desk: 610-771-1282

Cell: 215-720-0745

Fax: 610-664-6687

Email: [khood@thehearthatdrexel.org](mailto:khood@thehearthatdrexel.org)

The Hearth at Drexel  
238 Belmont Avenue  
Bala Cynwyd, PA 19004



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### Move-In Timeline

1. Contact the Sales Office to discuss eligibility criteria.
2. Complete and submit forms 1 and 2 of the Application for Admission and return to the attention of the Sales Office with supporting financial documentation. We must be able to verify income and assets.
3. You will be contacted to set-up a clinical assessment.
4. The Sales Office will contact your primary care physician to complete and forward the medical evaluation form for Assisted Living residents to the Sales Office. You must have seen your primary care physician within 60 days of move-in. We also require an updated medication list with a diagnosis for each medication with history and physical/last visit notes. We understand COVID-19 restrictions will effect this request and we will work through it together.
5. **Due to COVID-19 restrictions, we will reserve your apartment and coordinate a smooth move-in.**
6. As a depositor, you will receive a high level of contact via email with updates. When we are able to confirm your move-in date, we suggest a move-in arrival time Monday through Friday between 10 AM and 3 PM. This ensures each Resident and family gains timely access to our move-in team.
7. Your contract and additional move-in paperwork can be completed three days before move-in date. We can review the paperwork together via phone or virtual meetings.

Thank you for your understanding. We look forward to you joining us at The Hearth at Drexel!

*Kylie Hood, CDP*  
*Director of Sales & Marketing*

**Please Print**

Applicant's Full Name			
Street Address			
City	County	State	Zip
Telephone Number (    )		Alternate Telephone Number (    )	
Social Security Number			
Medicare Number			
Secondary Insurance			
Account/Policy Number			
Other Insurance Provider			
Account/Policy Number			
Prescription Plan <input type="checkbox"/> Yes <input type="checkbox"/> No			
Name			
Account/Policy Number			
<b>Current Living Status</b>			
<input type="checkbox"/> Home <input type="checkbox"/> With no home health services <input type="checkbox"/> With home health services			
<input type="checkbox"/> Hospital Name			
<input type="checkbox"/> Nursing or Personal Care Home Name			
<input type="checkbox"/> Other			
Approximate date you wish to enter The Hearth at Drexel			
How did you hear about The Hearth at Drexel? <input type="checkbox"/> Self <input type="checkbox"/> Friends <input type="checkbox"/> Church <input type="checkbox"/> Family			
<input type="checkbox"/> The Hearth Staff <input type="checkbox"/> Social Service <input type="checkbox"/> Physician			
<input type="checkbox"/> Advertisement <input type="checkbox"/> Website <input type="checkbox"/> Social Media			
<input type="checkbox"/> Other			

<b>Personal Information</b>			
Age	Date of Birth	Place of Birth	
US Citizen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<input type="checkbox"/> Caucasian	<input type="checkbox"/> African American	<input type="checkbox"/> Hispanic	<input type="checkbox"/> Native American
<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Widow/Widower	<input type="checkbox"/> Divorced
<input type="checkbox"/> Asian			
<input type="checkbox"/> Other			
Lifetime Occupation			
Veteran	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Branch: _____
Veterans Benefits		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Highest Level of Education	<input type="checkbox"/> No schooling	<input type="checkbox"/> 8 <sup>th</sup> Grade/Less	<input type="checkbox"/> 9-11 Grades
<input type="checkbox"/> Technical/Trade School	<input type="checkbox"/> Some College	<input type="checkbox"/> Bachelor's Degree	<input type="checkbox"/> Graduate Degree
Known Allergies			
Hair Color:		Eye Color:	
Father's Full Name			
Mother's Full Name			
Mother's Maiden Name			
Spouse's Full Name			
<input type="checkbox"/> Living		<input type="checkbox"/> Deceased	
<b>Physician Information</b>			
Name of Primary Physician			
Name of Practice			
Street Address			
City	County	State	Zip
Office Telephone Number (    )			
<b>Preferred Hospital:</b>			
<b>Religious Information (Optional)</b>			
Religion			
Involvement	<input type="checkbox"/> Active	<input type="checkbox"/> Attendance Only	<input type="checkbox"/> Inactive
<input type="checkbox"/> None			
Name of Church/Synagogue			
Telephone Number (    )			
Name of Pastor/Priest/Rabbi			
Street Address			
City	County	State	Zip

<b>Billing Information</b>			
Power of Attorney	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name
Guardian	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name
Name of Person to Receive/Pay Monthly Statements			
Relationship to Applicant			
Street Address			
City	County	State	Zip
Home Telephone Number (    )		Work Telephone Number (    )	
Cell Phone Number (    )		E-mail Address	
<b>Primary Contact</b>			
Name of Person to Contact in Emergency			
Relationship to Applicant			
Street Address			
City	County	State	Zip
Home Telephone Number (    )		Work Telephone Number (    )	
Cell Phone Number (    )		E-mail Address	
<b>Second Contact</b>			
Name of Person When Primary Contact is Unavailable			
Relationship to Applicant			
Street Address			
City	County	State	Zip
Home Telephone Number (    )		Work Telephone Number (    )	
Cell Phone Number (    )		E-mail Address	
<b>Third Contact</b>			
Name of Person When Primary Contact is Unavailable			
Relationship to Applicant			
Street Address			
City	County	State	Zip
Home Telephone Number (    )		Work Telephone Number (    )	
Cell Phone Number (    )		E-mail Address	

<b>Funeral Arrangements</b>			
Name of Funeral Director			
Street Address			
City	County	State	Zip
Funeral Home Telephone Number (    )			
Name of Person Responsible for Funeral Arrangements			
Applicant's Relationship to this person			
Home Telephone Number (    )		Work Telephone Number (    )	
Cell Phone Number (    )			
Do you have an Advanced Directive/Living Will? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Would you like additional information on Advanced Directives? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<b>Please submit a copy of Power of Attorney and Advanced Directive/Living Will if these documents exist.</b>			
Signature of Applicant			
Date			
Signature of Person Completing This Form			
Print Name			
Relationship to Applicant			
Date			

**Please disclose all available assets and attach current statements to validate with applicant's name listed on statement. Statements must be provided for approval.**

Income		
Type	Amount Per Month	Total Amount Annually
Social Security	\$	\$
Pension	\$	\$
Annuity/Trust	\$	\$
Rental	\$	\$
Dividends	\$	\$
Interest	\$	\$
Bonds	\$	\$
Other Income	\$	\$
Other Income	\$	\$
<b>Total Income</b>	<b>\$</b>	<b>\$</b>
<b>Banking</b> <i>Please attach current statements.</i>		
Checking Accounts: Bank(s)		Current Balance
1		\$
2		\$
3		\$
Savings Account, CDs, Money Market, Banks, Other		
1		\$
2		\$
3		\$

<b>Stocks/Bonds</b> <i>Please attach investment statements.</i>				
Stocks: Company	Number of Shares	Current Value		
1		\$		
2		\$		
3		\$		
Bonds	Type	Current Value		
1		\$		
2		\$		
3		\$		
<b>Real Estate</b> <i>(Please note any jointly held property) Please attach any appraisal or listing agreement, if applicable.</i>				
Real Estate <i>(In Applicant's Name)</i> : Please provide home appraisal in writing for each property from realtor/broker/attorney.				
Type and Location <i>(List Address)</i>		Value	Mortgage Amount	
1		\$	\$	
2		\$	\$	
3		\$	\$	
Are you planning to sell any/all of your real estate?		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>Do you have a Long Term Care Insurance policy?:</b> (Attach copy)		<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Provider:		Daily Rate:		
<b>Life Insurance Policies</b> <i>(On Applicant's Life or owned by the Applicant)</i>				
Company	Policy Number	Face Value	Cash Value	Beneficiary
1		\$	\$	
2		\$	\$	
3		\$	\$	
Describe any debts, mortgages, obligations, etc., affecting income or assets:				
In the past five years, have you given any gifts exceeding \$5000? <input type="checkbox"/> Yes <input type="checkbox"/> No If so, in what amount and to whom?				





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I, signatory below, affirm that the foregoing is a true statement of the facts known to me and is submitted as part of an application for residence in the community. I understand that a lack of truth in my statements in this application is grounds for either a denial of admission a discharge after admission. Further, if admitted, I affirm that, while I am in residence at the community, (a) I will use the funds and resources I have identified above, as well as all income received from these funds and resources and any other income which I may receive while I remain in residence at the community, primarily for payment to the facility for services provided to me; and, (b) I will submit an Annual Statement of my financial status to the community. Finally, I hereby also authorize any and all financial institutions or entities with whom I have a business, commercial or fiduciary relationship to release any and all requested financial information to the community as long as I remain in residence at the community.

Signature of Applicant \_\_\_\_\_ Date \_\_\_\_\_

Signature of Person Completing This Form \_\_\_\_\_ Date \_\_\_\_\_

Power of Attorney \_\_\_\_\_ Date \_\_\_\_\_

Guardian \_\_\_\_\_ Date \_\_\_\_\_

*The Civil Right Act of 1964 prohibits discrimination. The word "discrimination" shall be understood to mean "discrimination on the basis of race, color, national origin, ancestry, religious creed, sex, age or handicap," as used in Title VI of the Civil Rights Act of 1964, the Pennsylvania Human Relations Act of 1955, as amended, Section 504.*