Otterbein SeniorLife

APPLICATION FOR RESIDENCY

PERSONAL INFORMATION

Applicant's Full Name:_____

Address: _____

City _____ State _____ Zip Code_____

Email address_____

Telephone Number/cell number_____

Date of Birth _____ Social Security Number_____

Birthplace _____

County of Residence _____ How long _____

City _____ State _____

Occupation (previous, if applicable) _____ Retired_____

Military Service: ◯ Yes ◯ No Branch of Service: _____

Marital Status (check one) ◯ Single ◯ Married ◯ Widowed ◯ Divorced

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Spouse's Name: _____ Date of Birth: _____

Occupation (previous, if applicable)_____

Social Security #_____

Anniversary Date _____

Email _____ Phone Number_____

PETS

Do you own any pets? _____ If yes, please indicate: ◯ Dog ◯ Cat ◯ Other _____

If you own pet(s), Otterbein requires a non-refundable pet fee prior to occupancy.

FAMILY INFORMATION

EMERGENCY CONTACTS: 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 care:
(Indicate Mr., Mrs., Miss, Ms., Dr., Rev.)

Name: _____ Relationship: _____

Address: _____ Email _____

City: _____ State: _____ Zip Code: _____

Telephone: Home Number: _____ Business Number: _____

Cell Number: _____

2nd CONTACT

Name: _____ Relationship: _____

Address: _____ Email _____

City: _____ State: _____ Zip Code: _____

Telephone: Home Number: _____ Business Number: _____

Cell Number: _____

3rd CONTACT

Name: _____ Relationship: _____

Address: _____ Email _____

City: _____ State: _____ Zip Code: _____

Telephone: Home Number: _____ Business Number: _____

Cell Number: _____

FINANCIAL REPRESENTATIVE: **(*Person/business to receive monthly bills IF other than self)**

Name: _____ Relationship: _____

Address: _____ Email _____

City: _____ State: _____ Zip Code: _____

Telephone: Home Number: _____ Business Number: _____

Cell Number: _____

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 mortgage*	$_____
*remaining balance on mortgage	$_____
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? _____ 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)? _____

To _____ Asset _____

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HEALTH INSURANCE:

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

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 _____

Long Term Care Insurance: ◯ **Yes** ◯ **No**

Company _____ Policy Number _____

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

◯ Yes ◯ No Plan A Policy Number _____

COMPLETE BELOW FOR SPOUSE

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

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 _____

Long Term Care Insurance: ◯ **Yes** ◯ **No**

Company _____ Policy Number _____

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

◯ Yes ◯ No Plan A Policy Number _____

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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.

The undersigned person(s) authorizes Otterbein Homes to contact the sources provided for verification of the information provided on this application.

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 _____ Spouse _____
Print Print

Signature _____ Signature _____

Date _____ Date _____

When complete, please email this to your sales counselor. If you have not yet spoken to a sales counselor, please email to admissions.cp@otterbein.org.

Otterbein SeniorLife adheres to all regulations as written in The Fair Housing Act and prohibits discrimination because of race, color, national origin, religion, sex (including gender identity and sexual orientation), familial status, and disability, whether it be mental or physical.