

ASSETS

Cash on Deposit\$ _____
 Checking Accounts.....\$ _____
 Savings and Money Market Accounts\$ _____
 Certificates of Deposit\$ _____
 Notes Receivable (attach schedule).....\$ _____
 Market Securities\$ _____
 Stocks (current value)\$ _____
 Bonds (current value)\$ _____
 Funds in Trust (provide copy of trust)\$ _____
 * Real Estate (submit appraisal).....\$ _____
 ** Life Insurance (cash value)\$ _____
 Annuity (include value).....\$ _____
 IRAs (balance / beneficiary)\$ _____
 Other Assets (attach schedule).....\$ _____
 TOTAL ASSETS\$

LIABILITIES

Home Mortgage.....\$ _____
 Loans & Installment Payments\$ _____
 Other Liabilities (attach schedule).....\$ _____
 TOTAL LIABILITIES\$
 NET ASSET BALANCE.....\$



APPLICATION FOR RESIDENCY



A Division of Lutheran Retirement Ministries
 of Alamance County, North Carolina

Date Received _____
 Date Accepted _____
 Proposed date for Occupancy _____
 Application Number _____

- HEALTHCARE
- ASSISTED LIVING
- MEMORY CARE

* Regarding Real Estate:
 If you plan to maintain ownership of any real estate after your move to Twin Lakes, please submit a schedule of your real estate holdings including ownership, address, market value, and any rental income received from such properties.

** Regarding Life Insurance: Please complete the following:

Face Value of Applicant's Policy:
 \$ _____

Applicant's Beneficiary:

Name _____ Date of Birth _____ Age _____
 Present Address _____ Place of Birth _____
 City _____ State _____ Zip _____
 County/State of Legal Residence _____
 How long have you been a resident of that County? _____ Home Phone _____
 Home Address (if different from above) _____
 City _____ State _____ Zip _____
 Social Security No. _____
 Your Profession, Trade or Occupation _____
 Medicare No. _____ Medicaid No. _____
 Marital Status: Married [] Divorced [] Widowed [] Single []
 Full Name of Husband or Wife _____
 His/Her Social Security No. _____ Date of Marriage _____
 Address (if living and if different from above) _____
 Home Phone _____
 With whom are you living now? _____ How long? _____
 Local Physician _____
 Of what church are you a member? _____
 City _____ State _____ Zip _____
 Pastor's Name _____

DO YOU HAVE A POWER OF ATTORNEY? Yes [] No []
 DO YOU HAVE A HEALTHCARE POWER OF ATTORNEY? Yes [] No []
 DO YOU HAVE A LEGAL GUARDIAN? Yes [] No []

Please include copies of any or all of these documents.

Full Name _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone _____ Office Phone _____ Other Phone _____

The medical, personal and financial information submitted by the applicant within this application is a material part for determination of a contract agreement. Any misrepresentation or omissions are considered a breach of contract.

DATE _____ SIGNATURE _____
 DATE _____ SIGNATURE _____

PLEASE ATTACH A COPY OF YOUR:

- Social Security Card
- Medicare Card
- Medicaid Card
- Medical Insurance Cards / Prescription Plan Card
- Power of Attorney Documents
- Healthcare Power of Attorney
- Guardianship Documents
- Advanced Healthcare Directives

DO YOU HAVE ANY ADVANCE HEALTHCARE DIRECTIVES? Yes [] No [] *Include copies of documents.*

Type _____

RESPONSIBLE PARTY - *Please provide information on person who will handle financial affairs.*

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____ Other Phone _____

CONTACT PERSONS - *Please provide information on those individuals who should be notified in case of emergency.*

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____ Other Phone _____

Name _____ Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Office Phone _____ Other Phone _____

MEDICAL INSURANCE

Company Name _____ Policy No. _____ Group No. _____

Address _____ Phone _____

City _____ State _____ Zip _____

ARE YOU CURRENTLY ENROLLED IN A MEDICARE OR HMO INSURANCE PLAN? Yes [] No []

Company Name _____ Policy No. _____ Group No. _____

Address _____ Phone _____

City _____ State _____ Zip _____

LONG-TERM CARE INSURANCE

Company Name _____ Policy No. _____ Amount _____

Address _____ Phone _____

City _____ State _____ Zip _____

RESIDENT FINANCIAL INFORMATION

The following information is requested to assure the Board of Lutheran Retirement Ministries that your financial resources will be adequate to fulfill your responsibilities at Twin Lakes Community. The information supplied is strictly confidential.

MONTHLY INCOME

Social Security..... \$ _____

Private Pension..... \$ _____

IRAs..... \$ _____

Annuities \$ _____

Installment Notes..... \$ _____

Rental Income \$ _____

Dividend Income..... \$ _____

Interest Income..... \$ _____

Other (attach schedule)..... \$ _____

TOTAL MONTHLY INCOME \$

Does pension provide surviving spouse benefit / percentage? _____

Does pension provide cost of living increases? _____

MONTHLY EXPENSES

Estimated monthly living expenses
(such as food, car, entertainment) \$ _____

Estimated monthly medical expenses
(including prescription medications) \$ _____

Monthly insurance payments
(including health, life, LTC, property) \$ _____

TOTAL MONTHLY EXPENSES \$