



Application Number _____

Date Received _____

Date Approved _____

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

APPLICATION FOR RESIDENCY

A non-refundable \$250 fee is required with application submittal.
Updated health and financial information may be requested before a contract is executed.

FOR APPLICANT:

1. Name _____
Last First Middle

2. Street Address _____
City/State Zip _____

3. Social Sec. Number _____

4. Telephone Number _____

5. Date of Birth _____

6. Email Address _____

7. Emergency Contact:

Name _____

Address _____

City/State _____

Relationship _____

Phone Number _____

8. Marital Status: Married Single Widowed
 Divorced Remarried

17. Desired date for residency (Please be as specific as possible.) _____

18. Type of accommodations requested:

Apartments: Heather Laurel

Wittenberg Apartments: Edelweiss Iris Valerian

Stockton Apartments: Magnolia Oak Poplar Redbud Sycamore Tupelo Willow

Villas: Acacia Aspen Chestnut Birch Dogwood

Garden Homes: Juniper Evergreen Forsythia Gardenia Holly

FOR CO-APPLICANT:

9. Name _____
Last First Middle

10. Street Address _____
City/State Zip _____

11. Social Sec. Number _____

12. Telephone Number _____

13. Date of Birth _____

14. Email Address _____

15. Emergency Contact:

Name _____

Address _____

City/State _____

Relationship _____

Phone Number _____

16. Marital Status: Married Single Widowed
 Divorced Remarried

FOR APPLICANT:

11. Financial Power of Attorney_____

12. Medical Power of Attorney_____

13. Where have you lived most of your life?_____

14. Vocation(s) or profession(s) in which you have engaged_____

15. Skills, Interests, Hobbies_____

16. Community Service_____

FOR CO-APPLICANT:

11. Financial Power of Attorney_____

12. Medical Power of Attorney_____

13. Where have you lived most of your life?_____

14. Vocation(s) or profession(s) in which you have engaged_____

15. Skills, Interests, Hobbies_____

16. Community Service_____

FOR BOTH APPLICANTS:

17. How did you first hear about Twin Lakes?_____

18. What appealed to you most about Twin Lakes?_____

RESIDENT FINANCIAL DATA

The following information is required to assure us that your financial resources will be adequate to fulfill your responsibilities at Twin Lakes Community. If there are assets that will never be liquidated, please discuss these with the Sales and Marketing representative. The information supplied is strictly confidential. The decision to admit or not admit an applicant is made by Twin Lakes Community at its sole discretion. The applicant agrees to such decision as binding and final in all aspects.

ASSETS*

APPLICANT

CO-APPLICANT

(check box if jointly held account)

Cash on Deposit.....	\$ _____ []	\$ _____
<small>(including checking accounts, savings accounts, money market accounts, and certificates of deposit)</small>		
Notes Receivable (<i>attach schedule</i>).....	\$ _____ []	\$ _____
Marketable Securities		
Stocks/Equity Funds (current value)	\$ _____ []	\$ _____
Bonds/Bond Funds (current value)	\$ _____ []	\$ _____
Funds in Trust (<i>copy of trust must be attached</i>)	\$ _____ []	\$ _____
Primary Residence (current market value).....	\$ _____ []	\$ _____
Do you intend to sell upon entry? [] Yes [] No		
Other Real Estate (current market value)	\$ _____ []	\$ _____
Do you intend to sell upon entry? [] Yes [] No		
Annuity (include balance).....	\$ _____ []	\$ _____
Do you have unrestricted access to the principal balance of the annuity? [] Yes [] No		
IRAs/401K (balance)	\$ _____ []	\$ _____
Other Assets (attach schedule).....	\$ _____ []	\$ _____
<small>(DO NOT include autos, antiques, household goods, etc)</small>		

TOTAL ASSETS	\$ _____ []	\$ _____
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Will all assets be inherited by surviving applicant? [] Yes [] No *If no, please attach explanation.*

*Documentation of all assets and income will be required at the time a specific home is chosen for residency prior to the issuance of a contract.

LIABILITIES

Home Mortgage.....	\$ _____ []	\$ _____
Auto and Credit Card Debt	\$ _____ []	\$ _____
Other Liabilities or Debt Guarantees (attach schedule)	\$ _____ []	\$ _____

TOTAL LIABILITIES	\$ _____ []	\$ _____
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NET ASSET BALANCE	\$ _____ []	\$ _____
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LIFE INSURANCE

Face Value of Applicant's Policy \$ _____ Face Value of Co-Applicant's Policy \$ _____

Applicant's Beneficiary _____ Co-Applicant's Beneficiary _____

If this is a term life policy please provide expiration date of death benefits.

MONTHLY INCOME

APPLICANT

CO-APPLICANT

Social Security.....	\$ _____	\$ _____
Private Pension.....	\$ _____	\$ _____
a. surviving spouse benefit / percentage?	_____ %	_____ %
b. cost of living increases?	[] Yes [] No	[] Yes [] No
IRAs/401K.....	\$ _____	\$ _____
Annuities	\$ _____	\$ _____
Installment Notes	\$ _____	\$ _____
Rental Income.....	\$ _____	\$ _____
Dividend Income.....	\$ _____	\$ _____
Interest Income.....	\$ _____	\$ _____
Other (attach schedule)	\$ _____	\$ _____

TOTAL MONTHLY INCOME	\$ _____	\$ _____
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MONTHLY EXPENSES (Anticipated expenses at Twin Lakes NOT including monthly maintenance fee.)

Estimated monthly living expenses	\$ _____	\$ _____
(such as food, car, entertainment, personal items, additional utilities)		
Estimated monthly medical expenses	\$ _____	\$ _____
(including prescription medications, copay/deductible payments, etc.)		
Monthly insurance payments; <i>do not include LTC premiums</i>	\$ _____	\$ _____
(including health, life, personal property, auto)		
Family Support/Alimony*.....	\$ _____	\$ _____

TOTAL MONTHLY EXPENSES	\$ _____	\$ _____
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*Please list any support you provide, whether or not you are legally obligated to provide the support.

INSURANCE

APPLICANT

Traditional Medicare Part A [] Yes [] No
Replacement or Advantage Medicare Plan [] Yes [] No
If Yes, Name of Company _____
Supplemental/Extended Ins. [] Yes [] No
If Yes, Name of Company _____

Long-term Care? _____ Annual Premium _____
Benefit Period _____ Daily Benefit _____
Elimination Period _____ Inflation Adj. _____
Company Name _____

Applicant Signature _____
Date _____

CO-APPLICANT

Traditional Medicare Part A [] Yes [] No
Replacement or Advantage Medicare Plan [] Yes [] No
If Yes, Name of Company _____
Supplemental/Extended Ins. [] Yes [] No
If Yes, Name of Company _____

Long-term Care? _____ Annual Premium _____
Benefit Period _____ Daily Benefit _____
Elimination Period _____ Inflation Adj. _____
Company Name _____

Applicant Signature _____
Date _____

I certify that the foregoing information is a true and complete statement of facts regarding my financial status as known to me. I agree to provide any additional information that Twin Lakes Community may reasonably require. I understand that if accepted for residency, I will not transfer or reduce resources necessary to fulfill my commitment. I understand that if any information contained in the application is materially inaccurate or incomplete, my residency agreement may be subject to cancellation.

SELF-STATED PERSONAL HEALTH HISTORY

History and Physical (H&P) documentation must be obtained from your physician and included with your application.
The application is considered incomplete without the H&P information.

APPLICANT INFORMATION:

1. Applicant Name _____

2. Estimate, in your own words, the condition of your health:

3. Please list your current: Age _____ Weight _____ Height _____

4. Do you or have you ever had any of the following? (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Failure/Dialysis | <input type="checkbox"/> Glaucoma or
Macular Degeneration |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Incontinence of Bowel or Bladder |
| <input type="checkbox"/> Substance Abuse/Alcoholism | <input type="checkbox"/> Parkinson's or Other
Neurological Disorders | <input type="checkbox"/> Spinal Stenosis |
| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chronic Pain |
| <input type="checkbox"/> Heart Disease or
History of Heart Attack | <input type="checkbox"/> Memory Difficulties | <input type="checkbox"/> Circulatory Problems or
Swelling in Feet or Legs |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Difficulty Ambulating | |

Have you ever been hospitalized for any of the above? If so, please describe:

5. Do you use any of the following equipment?

- | | | |
|-------------------------------------|--|---|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Power Chair/Scooter | <input type="checkbox"/> In Home Dialysis Equipment |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Oxygen | <input type="checkbox"/> Feeding Tube |
| <input type="checkbox"/> Cane | <input type="checkbox"/> Hoyer Lift | |

6. Describe in detail any mental illnesses, memory loss or substance abuse/alcoholism you have experienced.
Please specify diagnosis, date of onset, and current status:

7. Do you smoke? Yes No

Twin Lakes Community is a tobacco-free community. Use of tobacco products is strictly prohibited.

8. Describe any past surgical operations, serious illnesses or hospitalizations not previously mentioned. Please give dates and details:

9. Please describe any mobility limitations:

10. Do you require any assistance with:

Dressing Bathing Ambulating/Walking Meal Preparation Taking Medications

11. Do you drive? Yes No

12. Do you live independently? Yes No If no, please describe current arrangements:

13. Please list your current primary care physician:

Name _____ Phone _____

Address _____

14. Do you see any specialty physicians? Please check all that apply:

Neurologist Psychotherapist/Psychiatrist Cardiologist Other

What conditions are you seeing these specialists for?

15. What are your current medications?

16. What medications, not listed in number 15, have you taken in the last year?

17. Please list any other pertinent health history or diagnosis not mentioned above:

18. Do you have any medical/personal care services you would be anticipating Twin Lakes Community to provide upon residency? If so, please describe:

The medical and personal information submitted by the applicant within this self-stated personal health history is a material part for determination of a contract agreement. Any misrepresentation or omissions are considered a breach of contract, permitting the contract to be declared null and void.

Date _____ Applicant Signature _____

SELF-STATED PERSONAL HEALTH HISTORY

History and Physical (H&P) documentation must be obtained from your physician and included with your application. The application is considered incomplete without the H&P information.

CO-APPLICANT INFORMATION:

1. Co-Applicant Name _____

2. Estimate, in your own words, the condition of your health:

3. Please list your current: Age _____ Weight _____ Height _____

4. Do you or have you ever had any of the following? (check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Kidney Failure/Dialysis | <input type="checkbox"/> Glaucoma or
Macular Degeneration |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Incontinence of Bowel or Bladder |
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| <input type="checkbox"/> Mental Illness | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Chronic Pain |
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10. Do you require any assistance with:

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11. Do you drive? Yes No

12. Do you live independently? Yes No If no, please describe current arrangements:

13. Please list your current primary care physician:

Name _____ Phone _____

Address _____

14. Do you see any specialty physicians? Please check all that apply:

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The medical and personal information submitted by the co-applicant within this self-stated personal health history is a material part for determination of a contract agreement. Any misrepresentation or omissions are considered a breach of contract, permitting the contract to be declared null and void.

Date _____ Co-Applicant Signature _____