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 ..... $ _____

* 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:

_____

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

EQUAL HOUSING OPPORTUNITY

APPLICATION FOR RESIDENCY

☐ HEALTHCARE
☐ ASSISTED LIVING
☐ MEMORY CARE

Twin Lakes COMMUNITY

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

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

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 _____

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..... $ _____