EQUAL HOUSING OPPORTUNITY

Twin Lakes COMMUNITY

Application Number _____

Date Received _____

Date Approved _____

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

APPLICATION FOR RESIDENCY

A non-refundable $700 fee is required with application submittal. Updated health and financial information, along with supporting documentation, will be requested before a contract is executed.

FOR APPLICANT:

1. Name _____
Last First Middle

2. Street Address _____

City/State Zip _____

3. Telephone Number _____

4. Date of Birth _____

5. Email Address _____

6. Emergency Contact:

Name _____

Address _____

City/State _____

Relationship _____

Phone Number _____

7. Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Remarried [ ] Domestic Partners

FOR CO-APPLICANT:

8. Name _____
Last First Middle

9. Street Address _____

City/State Zip _____

10. Telephone Number _____

11. Date of Birth _____

12. Email Address _____

13. Emergency Contact:

Name _____

Address _____

City/State _____

Relationship _____

Phone Number _____

14. Marital Status: [ ] Married [ ] Single [ ] Widowed [ ] Divorced [ ] Remarried [ ] Domestic Partners

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

16. Type of accommodations requested:

Aldersgate and Brandenburg 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 APPLICANT:

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

18. Vocations or professions in which you have engaged _____

19. Skills, Interests, Hobbies_____

_____

FOR CO-APPLICANT:

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

21. Vocations or professions in which you have engaged _____

22. Skills, Interests, Hobbies_____

_____

FOR BOTH APPLICANTS:

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

_____

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

_____

HEALTH INSURANCE

APPLICANT

Traditional Medicare Part A [ ] Yes [ ] No
Replacement or Advantage Medicare Plan [ ] Yes [ ] No
Supplemental/Extended Ins. [ ] Yes [ ] No
Name of Company_____

Long-term Care?_____ Annual Premium_____
Benefit Period_____ Daily Benefit_____
Elimination Period_____ Inflation Adj._____
Company Name_____

CO-APPLICANT

Traditional Medicare Part A [ ] Yes [ ] No
Replacement or Advantage Medicare Plan [ ] Yes [ ] No
Supplemental/Extended Ins. [ ] Yes [ ] No
Name of Company_____

Long-term Care?_____ Annual Premium_____
Benefit Period_____ Daily Benefit_____
Elimination Period_____ Inflation Adj._____
Company Name_____

APPLICANT 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. Please do not omit any assets, obligations or income sources on the following financial statement. If there are assets that you do not ever intend to liquidate, please share details on the nature of the assets and the reason you intend not to liquidate. The information supplied is strictly confidential. Your privacy is very important to us and is therefore reviewed only by Sales and Marketing, our CFO, and CEO. It is securely stored under lock and key.

ASSETS*

	APPLICANT (check box if jointly held account)		CO-APPLICANT
Cash NOT held in a trust or retirement account *(including checking accounts, savings accounts, money market accounts, and certificates of deposit)*	$_____	[ ]	$_____
Funds in Trust (***copy of trust must be attached***)	$_____	[ ]	$_____
Notes Receivable (***attach schedule***)	$_____	[ ]	$_____
Annuity NOT held in a trust or retirement account (***attach annuity policy summary from the issuing insurance company***)	$_____	[ ]	$_____
• Do you have unrestricted access to the principal balance of the annuity?	[ ] Yes [ ] No		[ ] Yes [ ] No
• Is there a penalty associated with early withdrawal?	[ ] Yes [ ] No		[ ] Yes [ ] No
If yes, what percentage?	_____%		_____%
Traditional IRA/401(k)	$_____		$_____
Roth IRA	$_____		$_____
Marketable Securities			
Stocks/Equity Funds	$_____	[ ]	$_____
Bonds/Bond Funds	$_____	[ ]	$_____
Primary Residence	$_____	[ ]	$_____
• Do you intend to sell upon entry?	[ ] Yes [ ] No		
Other Real Estate *Please provide information about the use (vacation, rental, commercial), revenue and expenses, and your ownership percentage.*	$_____	[ ]	$_____
• Do you intend to sell upon entry?	[ ] Yes [ ] No		
Other Assets (attach schedule) ***DO NOT*** *include autos, antiques, household goods, etc.*	$_____	[ ]	$_____
TOTAL ASSETS	$0.00	[ ]	$0.00

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	$0.00	[ ]	$0.00
NET ASSET BALANCE	$0.00	[ ]	$0.00

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 policy: Applicant_____ Co-Applicant_____

If this is a whole life policy, please provide cash value amount: Applicant_____ Co-Applicant_____

MONTHLY INCOME	APPLICANT	CO-APPLICANT
Social Security	$	$
Private Pension	$	$
• surviving spouse benefit percentage?	0.00% %	0.00% %
Traditional IRA/401(k)	$	$
Roth IRA	$	$
Annuities not held in an IRA	$	$
Installment Notes	$	$
Rental Income	$	$
Dividend Income	$	$
Interest Income	$	$
Other (attach schedule)	$	$
TOTAL MONTHLY INCOME	**$** 0.00	**$** 0.00

ANTICIPATED MONTHLY EXPENSES (Those NOT included in the Twin Lakes monthly fee)

Estimated monthly living expenses (such as food, car, entertainment, personal items)	$	$
Estimated monthly medical expenses (including prescription medications,copay/deductible payments, etc.)	$	$
Monthly insurance payments; *do not include LTC premiums* (including health, life, personal property, auto)	$	$
Family Support/Alimony*	$	$
TOTAL MONTHLY EXPENSES	**$** 0	**$** 0.00

*Please list any support you provide, whether or not you are legally obligated to provide the support.

I certify that the foregoing information is a true and complete statement of facts regarding my financial status as known to me.

Applicant Signature _____ Date_____

Co-Applicant Signature _____ Date_____

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)

- ☐ Tuberculosis
- ☐ Cancer
- ☐ Substance Abuse
- ☐ Alcoholism
- ☐ Mental Illness
- ☐ Heart Disease or History of Heart Attack
- ☐ Stroke
- ☐ Kidney Failure/Dialysis
- ☐ Diabetes
- ☐ Parkinson's or Other Neurological Disorders
- ☐ Difficulty Breathing
- ☐ Memory Difficulties
- ☐ Difficulty Ambulating
- ☐ Glaucoma or Macular Degeneration
- ☐ Spinal Stenosis
- ☐ Chronic Pain
- ☐ Circulatory Problems or Swelling in Feet or Legs
- ☐ Other Chronic Conditions (list below)

_____

_____

5. Please describe any mobility limitations.

_____

_____

6. Do you use any of the following equipment?

- ☐ Wheelchair
- ☐ Walker
- ☐ Cane
- ☐ Power Chair/Scooter
- ☐ Oxygen
- ☐ Hoyer Lift
- ☐ In Home Dialysis Equipment
- ☐ Feeding Tube

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

_____

_____

8. Describe any past surgical operations, serious illnesses or hospitalizations. Please give dates and details.

_____

_____

9. Do you smoke? ☐ Yes ☐ No

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

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 _____

Address _____

Phone _____

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. 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)

☐ Tuberculosis	☐ Kidney Failure/Dialysis	☐ Glaucoma or Macular Degeneration
☐ Cancer	☐ Diabetes	☐ Spinal Stenosis
☐ Substance Abuse Alcoholism	☐ Parkinson's or Other Neurological Disorders	☐ Chronic Pain
☐ Mental Illness	☐ Difficulty Breathing	☐ Circulatory Problems or Swelling in Feet or Legs
☐ Heart Disease or History of Heart Attack	☐ Memory Difficulties	☐ Other Chronic Conditions (list below)
☐ Stroke	☐ Difficulty Ambulating	

_____

_____

5. Please describe any mobility limitations.

_____

_____

6. Do you use any of the following equipment?

☐ Wheelchair	☐ Power Chair/Scooter	☐ In Home Dialysis Equipment
☐ Walker	☐ Oxygen	☐ Feeding Tube
☐ Cane	☐ Hoyer Lift	

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

_____

_____

8. Describe any past surgical operations, serious illnesses or hospitalizations. Please give dates and details.

_____

_____

9. Do you smoke? ☐ Yes ☐ No

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

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 _____

    Address _____

    Phone _____

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 _____